the Canadian Nurse

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MONTREAL

SEPTEMBER 1963

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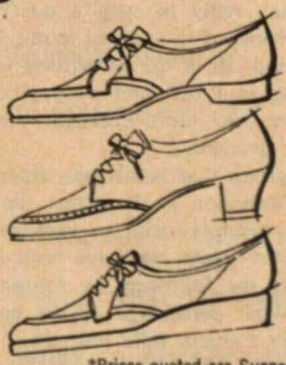

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Between Ourselves

Was your curiosity piqued by the centre page spread in the July issue ? Did you look to see what the special colored insert was all about last month ? Did you take the ten minutes it would require to fill in the answers on the three pages, and pop the completed questionnaire into the nearest mail box ?

What is it all about any way ? Why does the Canadian Nurses' Association want all of this information about the nurses of Canada ? Why is the form addressed to International Business Machines Data Centre ?

In every walk of life today, there is intense interest in statistical information. Your provincial association, for example, knows how many of the nurses have paid their membership fees for 1963, but in only a very few of the provinces were members asked to complete a form that is comparable to the one in this book. This is the first time that *all* nurses in Canada have been invited to provide detailed information about themselves. The I.B.M. Data Centre has undertaken to process on their computer cards all of the data from each form sent to them.

The completeness with which all of the pertinent information is recorded will determine the ultimate usefulness of the results. The Canadian Nurses' Association is asked a great variety of questions pertaining to nurses and nursing. Governmental departments, such as Emergency Health Services, may want to know how many nurses may be located in key areas. If only 25 per cent of the nurses respond to the questionnaire, obviously any reply to such a query will have to be couched in guarded terms. If, on the other hand, all of the subscribers to this *Journal* have sent off their c o m p l e t e d questionnaires, far more authentic answers will become available.

Another group that is intensely interested in such information is the firms that advertise their products with us each month. Over and over again, we have been asked for data like the following by *Journal* advertisers: "What percentage of the nursing profession in Canada falls into these categories: Nurse administrators, directors of nursing and/or directors of nursing services; central supply nurses; purchasing agents; obstetrical nurses, operating room nurses and supervisors, general staff nurses and supervisors. We have made a kind of sweeping guess like "approximately 80 per cent of the active nurses in Canada work in hospitals" but that is too vague, too indefinite an answer for specific inquiries. The care with which you complete the various sections of question number six will make such a difference in the quality of the replies we can make.

It would be of very real assistance if you would use your influence to persuade other nurses to complete their questionnaires, too. Like getting out to register our votes at election time, many of us are very casual about such a request as to complete a questionnaire. It really is important to nursing in Canada that you do. Let us try to get as close to 100 per cent returns as can possibly be achieved.

* * *

For this special series on urology, opinions and treatment information were sought from many centres. Despite the variety of topics that have been included, many aspects of the nursing care in urology have not been touched upon at all. In no branch of nursing is there offered a wider opportunity to perfect nursing as an art to the point where not only the patient's physical needs are met but where every effort is made to replace his fears and worries with a sense of security and the certainty that he will have the best care possible.

As a footnote to the necessarily brief but fascinating history of the present knowledge and practice of urology prepared by Dr. Legault, is the fact that urological instruments made of polished bronze were found in the excavations of the city of Pompeii that was buried by a volcanic eruption in 79 A.D. Among the instruments were several sounds of varying sizes, the largest having a double curve resembling those of modern make.

Three urological conditions with which the nurse working in the community may come in contact are tuberculosis of the urinary tract, gonorrhea and syphilis. Despite the advances that have been made in the treat-

(Continued on page 805)

THE CANADIAN NURSE

September 1963, Vol. 59, No. 9

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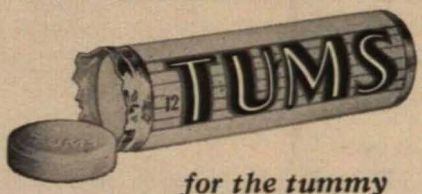

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Random Comments

Dear Editor:

The fifth annual Operating Room Nurses' Conference will be held November 12-14 inclusive at the University of Montreal.

The attendance last year exceeded 600 delegates from Quebec, Ontario, the Maritime provinces, the New England States and Bermuda. Judging from the letters of interest arising out of last year's conference, we expect this number to be increased by several hundreds. The auditorium foyer has been replanned to house the exhibits of some 32 companies.

Some of the subjects to be discussed by prominent authorities include: Functional aspects of hospital design; psychology in patient approach; orientation of professional and non-professional personnel; automation with regard to nursing.

Advance registration should be made to: Mrs. I. Adams, Operating Room Supervisor, Jewish General Hospital, Montreal, *or* Miss V. Audet, Operating Room Supervisor, Notre Dame de l'Espérance, Ville St. Laurent, Quebec.

E. CASEY, R.N., Montreal

Dear Editor:

I would like to express my appreciation for *The Canadian Nurse*. I find the articles interesting and informative — and helpful in that they keep my knowledge of the profession from stagnating. I love my work in this vast island — which has recently become a part of Indonesia — but I do appreciate the touch with the "outside world" that the *Journal* gives me. Many thanks for a fine magazine.

(Mrs.) MARGARET MARTIN, R.N., Indonesia.

Dear Editor

I was greatly amused on reading the letter of criticism, in the July issue, by Mrs. Margaret McDonald, S.R.N., R.F.N., S.C.M. Eng., R.N.

Her friend who did not read The Canadian Nurse — but threw it in the wastepaper basket without a scan — sounds to me like a nurse who would give a medicine without reading the label!

One will always find some Eskimos ready to instruct the Congolese on how to cope with a heat wave!

This "poverty of thought" is what creates

such chaos in the profession. I mean the type of chaos that destroys the order during creation and building.

I should like to read an article written by Mrs. McDonald on *her* idea of something interesting.

DOROTHY M. DENT, Ontario

Dear Editor:

I have enclosed a cheque for a two-year subscription to the *The Canadian Nurse*.

I am giving up my R.N.A.O. membership as I am now 71, and am not likely to be active again in nursing. I sincerely hope that this makes no difference to my receiving the journal. I lecture regularly for the Red Cross, and find so much material in this magazine to help my girls and keep their interest keen. In addition to this, I enjoy every page of it, and pass it along to my friends. Only seeing is believing the conditions under which the nurses in this country work.

(Mrs.) ETHEL WIJEWARDENE, Colombo, Ceylon.

Dear Editor:

I would like to draw the attention of your readers to the book *Florence Nightingale* by Cecil Woodham Smith.

After reading the biography of the "Lady with the Lamp," I have come to appreciate what she really accomplished. How many of us know what sacrifices, struggles and griefs she endured for our profession?

This is an excellent history for students and graduates. If you have not already read it, you will find it worthwhile to do so.

(Mrs.) C. MCMASTER, R.N., Germany.

¶ *This book was published in 1951 by McGraw-Hill Book Co., New York.* ED.

(Continued from page 798)

ment of these conditions with the preparations that have been developed in recent years, much education and preventive work must still be done.

Venereal disease work presents a special problem since efforts must be made both to secure adequate treatment for affected persons and also to combat the lingering prejudice and ignorance respecting the diseases. The nurse must resist the temptation to play the role of a reformer; her main object is to assist in the eradication of these highly contagious diseases.

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In some ways a diseased kidney gets better as it gets worse. Researchers at Washington University, St. Louis, have shown that as disease destroys part of the kidney, the still healthy portions work more efficiently to remove wastes and maintain vital chemical balance. The compensation is not complete but often suffices to mask symptoms for many years. These findings dispute long-held theories that kidney disease causes a generalized breakdown of the organ. They are likely to lead to some changes in the treatment of kidney ailments. — *Heart Research Newsletter*, vol. 8, Spring, 1963.

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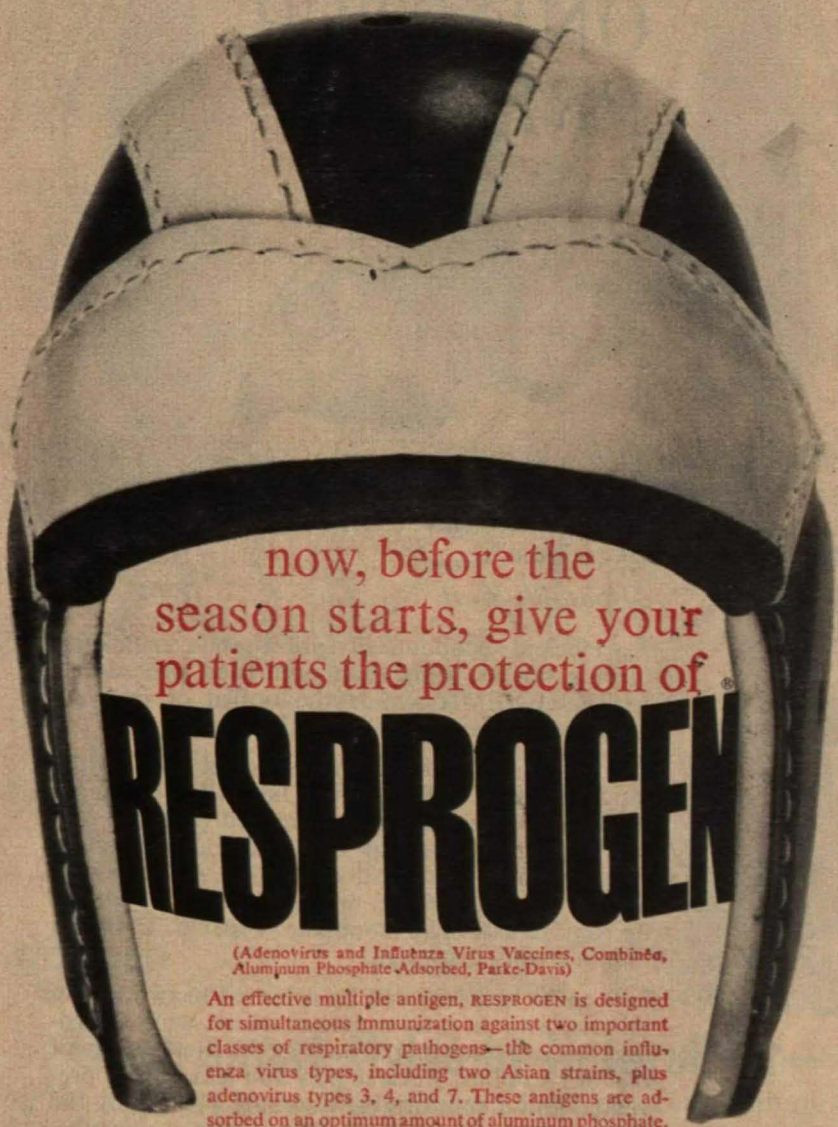

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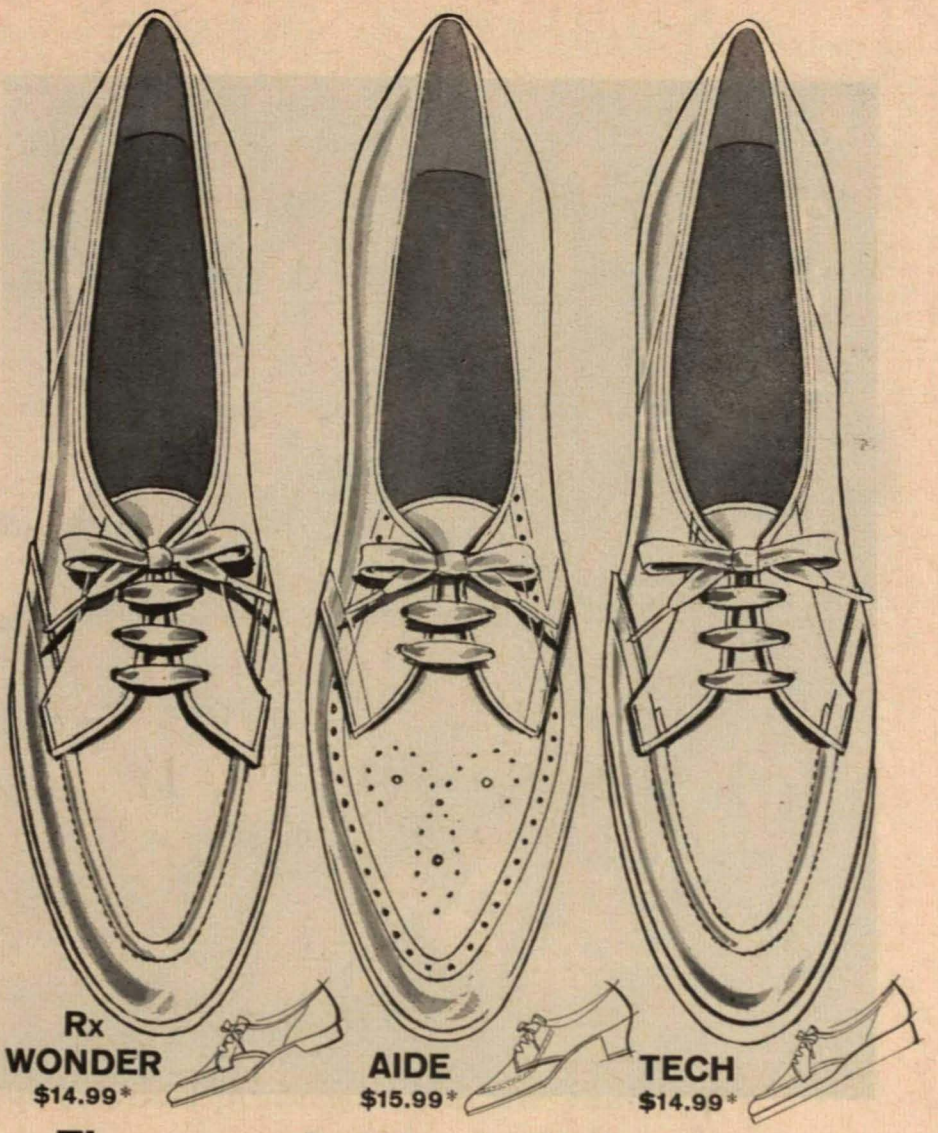

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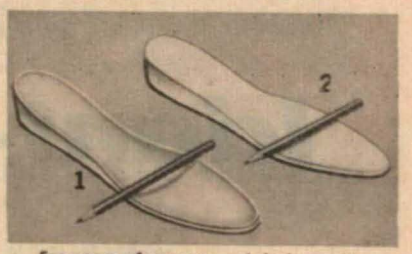

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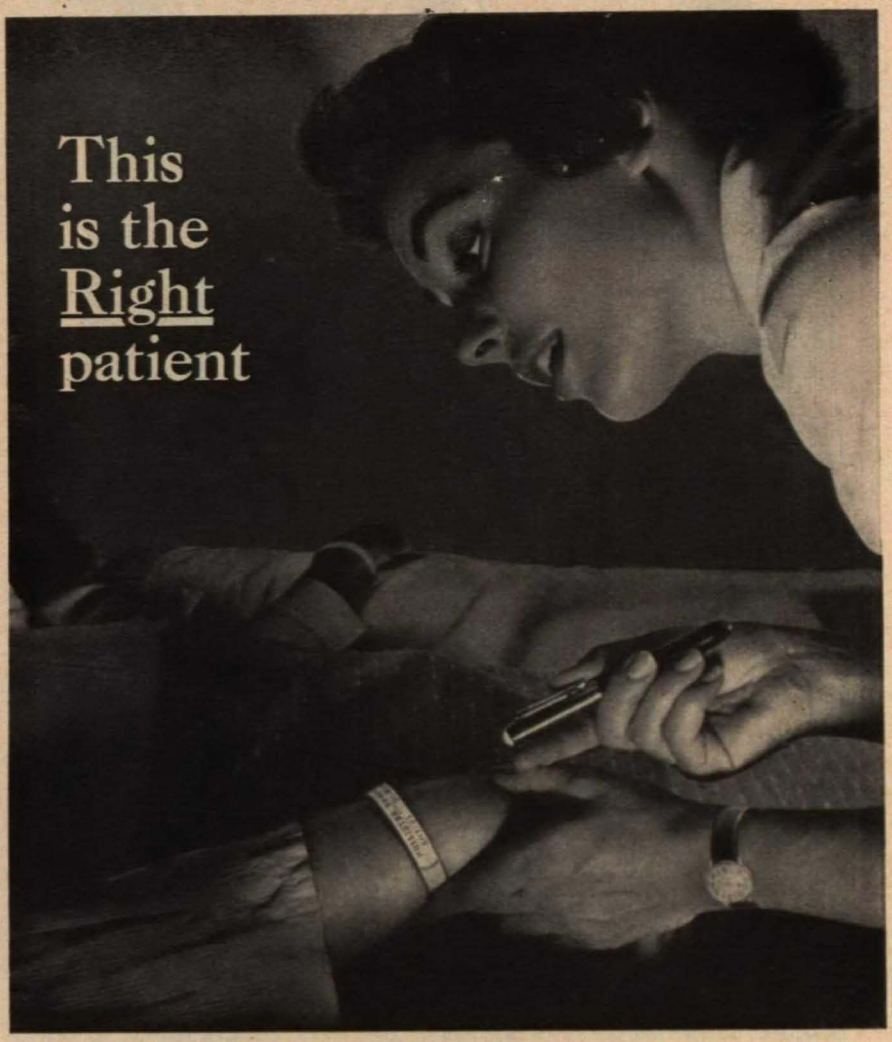

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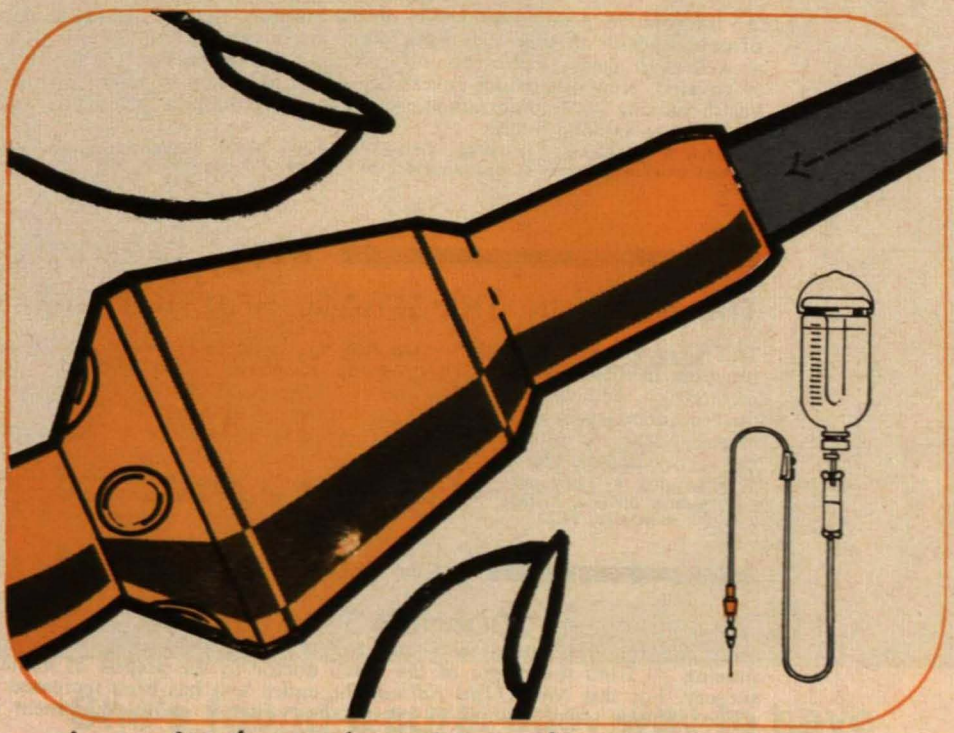

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- ☐ 3. Schwinner, M. and Mulinos, M. G.: Antibiot., Med. & Clin. Therapy 4:403, July, 1957.
- ☐ 4. Rosenberg, S. and Oster, K. S.: Conn. State Med. J. 19:171, March, 1955.
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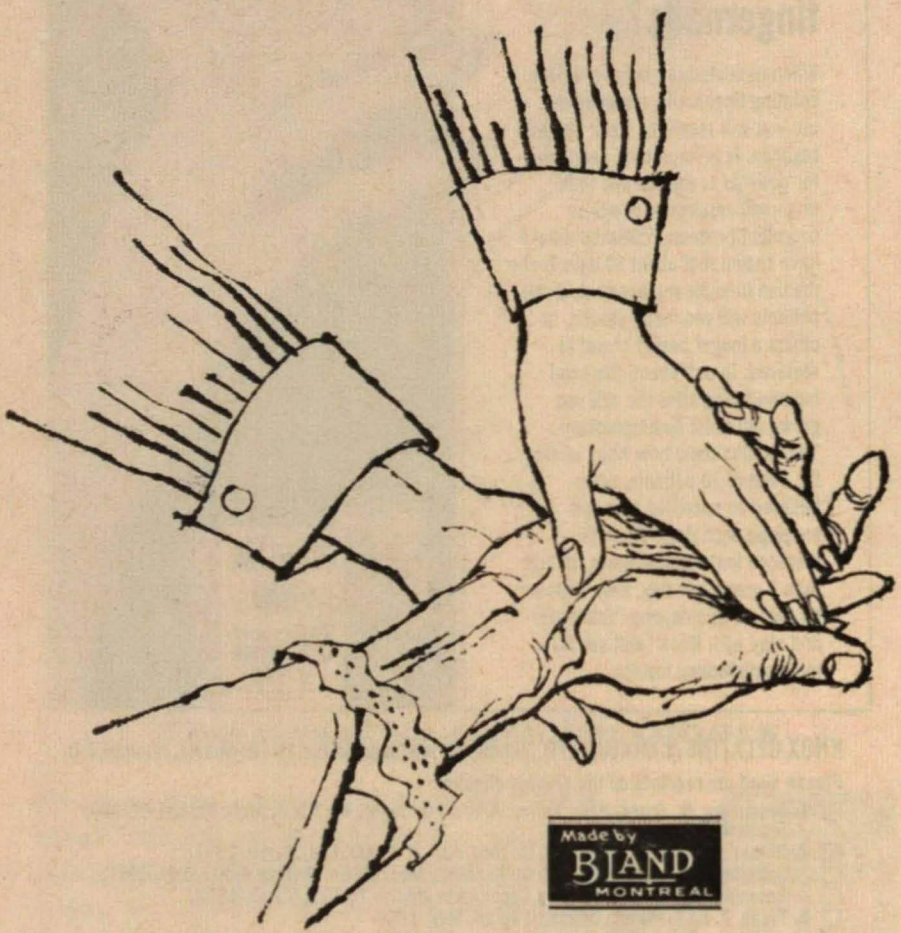

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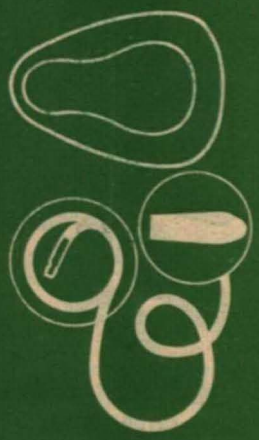

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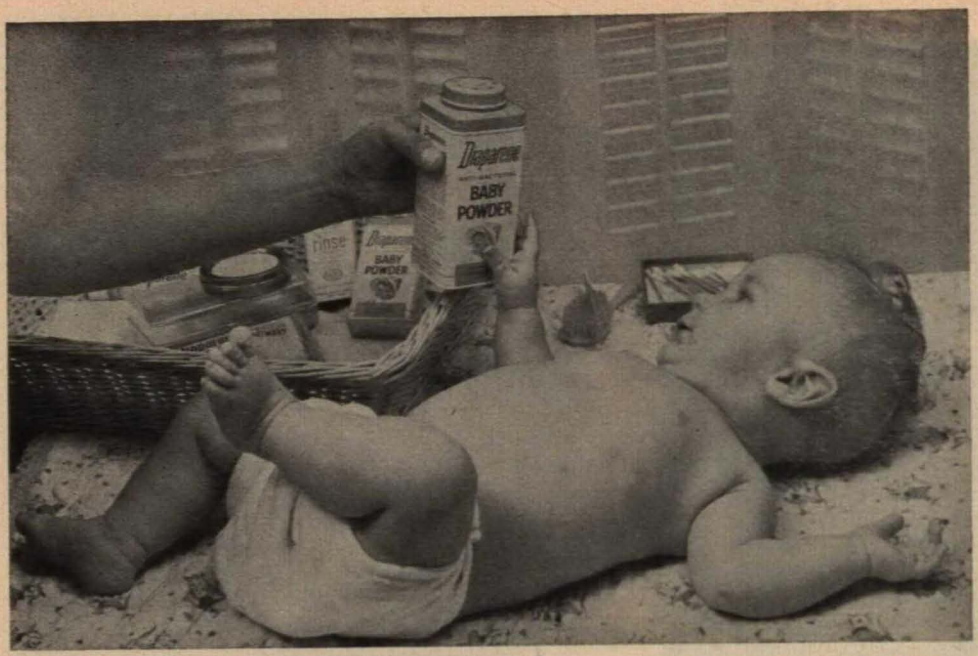

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UROLOGY IN REVIEW

JEAN-PAUL LEGAULT, C.U.R.C.S., F.A.C.S., F.I.C.S.

A fascinating story of the developments that have brought urology to its present level.

The branch of medical practice familiarly known to us as urology played an indisputably important role in past ages. It might even be asserted that it constituted early medicine. From the time of Hippocrates to Laennec, urinalysis was a prime factor in physical examination. In the Middle Ages, a doctor was, above all else, a good "judge of urine," and "observer of urine" from whence came the tendency to link the terms urology, urologist and uroscopy synonymously with medicine and medicos.

Observation of urine was a complex procedure, beginning with the question of color which ranged through a wide scale of basic colors and shades or tints thereof: white, golden yellow, reds, purple, green, etc. For example, white could be classified as crystal white, snow-white, milky-white, greenish-white or "water-white."

Urine was collected in a balloon-shaped glass receptacle known as a "matula" and since various corporate bodies tended to have identifying symbols, the doctors chose the "matula" as theirs. The ease with which these containers could be transported introduced the possibility of private consultation with the patient's family bringing the container in a little wicker basket to the doctor. This simplified medical practice appreciably since instead of spending an hour carrying out a physic-

Dr. Legault, a urologist, is associate professor on the medical staf of the Hôtel-Dieu Hospital, Montreal, Quebec.

al examination, inspection of the glass jar and its contents indicated the diagnosis and the treatment.

It is interesting to note that the urinal is probably the only bit of medical equipment ever to gain a place in church art. Depicted in the prayer-book miniatures of Queen Anne of Bretony, which dates from around 1508 are the patron saints of medicine, St. Como and St. Damien, holding a urinal and apparently studying its contents.

The replacement of alchemy by chemistry paved the way for the discovery of the components of urine and for diagnosis based on facts rather than imagination. Albumen was discovered in 1770 by an Italian investigator but its proportion in urine was not determined until 1870. Chevreuil demonstrated the presence of sugar in 1815 and the use of Fehling's reagent was introduced in 1850. In retrospect then, it is only slightly more than a century since the chemistry of urine was made known, replacing the earlier uncertainty as to its composition and resultant quackery. This, then, represents the medical aspects of urology but urological surgery prior to the 19th century must also be considered.

Two forms of surgical intervention were common in early practice: catheter drainage or probing, and lithotomy for removal of bladder calculi. The former dates back to the earliest history of mankind. In the 18th century the procedure was carried out using metallic sounds of which the eyes were filled with butter to prevent the instruments filling with blood. These sounds were stiff and traumatizing. Their use required the "master's touch." The present type of sounds was devised at the end of the 18th century by a silversmith in Paris, Bernard, who also produced silver surgical instruments. He used a silken material, impregnated with liquid rubber, allowed to harden and polished.

Lithotomy dates from Greek antiquity. The Hippocratic oath contained a clause by which the physician vowed to abstain from the practice of lithotomy and to leave it in the hands of mercenaries who made it their specialty. This latter group were somewhat of a mystery. They were apparently some type of nomadic bonesetters who travelled through Europe performing lithotomy on those affected with calculi. The names of some of these talented operators have been preserved, for example, that of the Collot family who formed a dynasty of lithotomists and in 1556 were, by royal appointment, made official court operators — a trust that they retained and for which they received an allowance until the reign of Louis XV.

To Jacques de Beaulieu, a monk who travelled throughout France performing lithotomy with great ceremony, goes the honor for developing lateral lithotomy. It is recorded that he performed no less than 4,500 operations in the course of his travels. The procedure was further perfected by another monk, Côme, who created an instrument with a concealed cutting blade that could be introduced into the bladder in a closed position and withdrawn with blades open. This instrument was used with further improvements up to the last century.

Finally, Franco, a native of Southern France and a surgical genius, invented and put into use for the first time in 1556, the procedure of suprapubic cystotomy. This method continued in popular practice following the introduction of aseptic technique until its replacement by crushing of the calculus *in situ* — a method that obviated the need for an incision and a long healing period.

Behind the use of suprapubic cystotomy lies a story. Franco encountered difficulty in removing a large calculus from a two-year-old child. His little patient recovered very well but was so ill that Franco, frightened by the procedure, counselled his colleagues against its use. Rousset, a doctor from Montpellier, studied the technique in detail using a cadaver, and determined that it was the truly ideal manner in which to remove calculi. His only regret was that the death of Henry III prevented him from experimenting on prisoners condemned to death, as the king had promised.

In view of the unfortunate results from lithotomy, some clever workers attempted to perfect instruments capable of crushing calculi within the bladder, thus permitting easier extraction through the urinary canal. Civiale, in

1824 and at age 27, performed the first litholapaxy using an ingenious instrument that grasped the calculus between blades and crushed it.

Reviewing the progress made, we note that urological surgery had its beginning in a dangerous form of intervention, carried out hurriedly with great pain for the patient due to lack of anesthesia. This was succeeded by gradual perfection of the equipment that could be used to remove calculi in large pieces and, finally, an instrument capable of reducing calculi to a fine gravel, permitting removal in a single operation. At present, progress in asepsis and surgical techniques has resulted in the tendency for more and more urologists to desert litholapaxy in favor of direct surgical intervention.

History records that many famous persons have suffered from the effects of urinary gravel and calculi. Among them were Louis XIV, Cromwell, Bacon, Bossuet, Buffon, Colbert, Montaigne and Napoleon I. When Dr. Fagon told Bishop Bossuet that he had a stone, the latter was horror-stricken, and expressed his desire for death rather than face operation. Later, Fagon himself underwent the operation, displaying great courage. Boileau suffered from calculi as a youth while Newton, Marmontel and d'Alembert were affected in old age.

Uretheral stricture was treated by Maisonneuve in 1855. Through a stroke of genius he succeeded in inventing a urethrotome that has been handed down unchanged from generation to generation. The most significant advance in diagnosis and treatment was brought about when Desormeaux, a surgeon from Necker Hospital, presented his endoscope before the Académie de Médecine in 1853. This made possible direct visualization of the ureter and the bladder as well as sight control over procedures. His equipment was essentially an optical instrument, enormous and cumbersome, dependent on a tiny oil lamp for illumination. But, such as it was, it represented an immense step forward since it opened up the era of direct examination of hollow viscera. Its chief fault lay in the poor degree of illumination which was provided by reflection of the light from outside the instrument with the result that the inner surface of the endoscope was more clearly visible to the examiner than the organ.

The problem was to find some means of lighting from within the organ. This was made possible only when electricity came into popular use. Nitze, a German urologist, used the new light source profitably and produced the present prismatic instrument. It was now possible to obtain an unobstructed view of the bladder with the aid of a tiny electric bulb beside a periscope-like tube which reflected the image. This was the cystoscope.

However, while this early model was a major step forward in the field, the cystoscope only came into its own when the South American, Albarran, a professor at Necker Hospital, added a duct capable of accommodating a long, fine sound that could be directed into the kidney by means of a tiny mobile lever on a toothed arc. The lever made it much easier for the operator to introduce the sound into the ureteral meatus. In its present form, the cystoscope has helped to save millions of lives.

As instruments of treatment, the cystoscope and ureteral sound may be utilized to place medications *in situ* and can contribute to the treatment of chronic infections in a much more active and effective manner than administration of drugs by mouth. It is within the field of diagnosis, however, that the cystoscope has proved of greatest value.

Ureteral catheterization also produced very favorable alterations in radiological diagnosis of renal lesions. It is a well-known fact that the kidney is easily overlooked in x-ray investigation. As a result large calculi and other lesions having the same consistency as surrounding tissue tend to go unnoticed. The ureteral sound has made possible the early diagnosis of cancer of the kidney. This dread condition becomes painful only in an advanced state and attracts the patient's attention if he is fortunate enough to void blood-tinged urine.

New inventions and improvements in equipment in themselves are not sufficient. This phase of urological development contributed much to the field

of diagnosis but it was only with the establishment of specific principles at the beginning of this century that urology became a highly precise and scientific branch of medicine. In almost all instances these principles arose out of the results of experimental physiology where, under comparable conditions, similar phenomena were reproduced.

Significant developments in biological chemistry were instrumental in placing urology in the category of an exact science. To understand kidney function and to determine if there was adequate elimination of waste products from the body, our predecessors depended on urinalysis. In 1903 Widal demonstrated that poor renal function resulted in a build-up of toxic products in the blood with resultant uremia. Using the work of Widal and of Achard concerning the regulating mechanism of blood composition as a starting point, Ambard determined the controlling mechanism of urine elimination and found a mathematical relationship between blood urea and that eliminated through urine. Clinically, Albarran and Guyon provided a masterful description of pyuria, hematuria and urinary infection. Lesions formerly attributed to urinary origin — fever, suppurative inflammation and infiltration — were properly diagnosed with the advent of bacteriology and the realization that the symptoms observed were due to the invasion of body tissues by microorganisms and not urine infiltration.

In the field of urological surgery where procedures, apart from nephrectomy, are usually conservative the main development has been removal of the prostate gland. Up to this century elderly men suffering from urinary retention due to prostatic conditions were doomed to a premature death as the result of toxicity and infection. Our age has witnessed the introduction of a procedure that has been as great a boon to the male as hysterectomy to the female — that is, prostatectomy.

This, then, is the story of the development of urology which, in the course of 50 years, has undergone complete transformation in the services offered to relieve suffering.

In the Good Old Days

(The Canadian Nurse — SEPTEMBER 1923)

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UROLOGICAL INVESTIGATIVE PROCEDURES

G. E. BONNELL, M.D.

The practice of urology as a branch of surgery dates back to the Dark and Middle Ages. Urology as a surgical specialty in its own right, however, is relatively new. It began about the middle of the 19th century, when it arose through demand for specialized treatment for venereal diseases and their dreaded complications. Since that time the specialty has been characterized by constant growth, facilitated by research in the basic sciences that has and is continuing to extend the boundaries of knowledge.

Urology today is a surgical specialty devoted to the diagnosis and treatment of diseases and abnormalities of the male and female urinary tract, the male genital tract and, at times, the adrenal glands. It is a specialty with its own associations and journals, many of which have attained an international status.

The present day urologist is primarily a surgeon. A basic prerequisite for acceptance to a urological training program is a sound background in general surgery. Since the urinary tract often serves as a window through which systemic diseases can be detected, and since many urological patients have associated medical conditions, the urologist should also have a firm background and interest in internal medicine.

INVESTIGATION AND DIAGNOSIS

In urology, the early diagnosis of a surgically remediable lesion may mean the difference between a normal life and a relatively early death from uremia. The specific aim is to prevent such a dreaded state by finding the site of the lesion and assessing its effect on the urinary tract and on the patient as a whole, and then to undertake specific treatment. Too often this aim is thwarted because patients with recurrent urinary tract infections have been treated with sulfonamides and antibiotics without investigation to exclude such states as calculi and obstructive lesions. As a result the infections are often kept in abeyance with antibacterial agents but the basic pathology has not been corrected. Too frequently the urologist first sees the patient when the disease has reached an advanced stage and treatment can only be palliative. This is most discouraging since the possibilities for obtaining an early accurate diagnosis in urology are more likely than in almost any other branch of medicine or surgery. Available instruments and techniques enable the urologist to view the entire urinary tract, either directly or indirectly.

Dr. Bonnell is a urologist with Fredericton Medical Clinic, Fredericton, N.B.

A) History and Physical Examination

A complete history and physical examination must be done. This may disclose systemic diseases or pathological processes in specific organs in patients presenting urological symptoms. Cardinal symptoms of urological diseases are:

1. Changes in micturition pattern: Increased frequency, urgency, incontinence, nocturia, hesitancy and abdominal straining in initiating micturition, decreased size and force of stream, painful urination and nocturnal enuresis.

2. Hematuria: This may be gross or microscopic in character.

3. Pyuria: Inflammatory cells in the urine.

4. Pain: This may be fixed in the loin, suprapubic area, rectum, or perineum. It may be colicky in nature, following the course of the ureter, or it may be poorly localized in the abdomen. The earliest manifestation of testicular torsion in infants and young children is periumbilical pain. Scrotal pain usually occurs later, often at a time when cellular death has occurred, and surgery is no longer corrective.

B) Examination of the Urine

As the study of rivers flowing into the ocean can give much information as to the composition of the mountains wherein the rivers originated, so can urinalysis give information regarding the body as a whole, the kidneys and lower urinary tract. A study of the urine to determine its concentration, color, acidity, sugar, protein, and a variety of crystals and cells, is one of the most important tests in clinical medicine. Even in advanced urological disease there may be a perplexing absence of symptoms. A urinalysis yielding abnormal results — often one required with an application for life insurance or employment — has frequently instigated complete urological examination. The urine to be examined should be freshly voided. Too often the specimen is allowed to sit overnight, sometimes at room temperature, leading to bacterial degradation. Examination relatively useless.

C) Endoscopy

The cystoscope and panendoscope are instruments employing multiple lenses with illumination. They allow the urologist to perform intricate diagnostic and surgical procedures which would otherwise be impossible. The urethral lumen, bladder, and ureteric orifices may be viewed by direct vision and bleeding points and other lesions localized. Tissue biopsies, particularly useful for the correct diagnosis of lesions simulating neoplasms, as well as estimation of the extensiveness of a neoplasm itself may be secured. The ureters may be catheterized and calculi removed from their lower portions as well as from the bladder.

D) Radiography

The use of x-ray is an essential adjunct to urology. In his investigation the urologist may employ multiple radiological procedures. He is, however, keenly aware of the dangers attendant upon radiation exposure, and he is able to keep this to a bare minimum by avoiding unnecessary procedures.

1. The intravenous pyelogram

If renal function is above 25 per cent of normal, the kidneys will clear the blood stream of an intravenously injected radiopaque medium and excrete it fast enough to afford visualization of the pelveocalyseal system, ureters, and bladder. If a film is taken during voiding, the urethra may be visualized as well. A film of the bladder after voiding will give a rough estimate of the amount of residual urine.

In addition to localizing abnormalities of the urinary tract, the intravenous pyelogram also gives a gross estimate of renal function by allowing a comparison of the density of the skeleton to that of the radiopaque medium in the renal collecting system.

2. The Retrograde Pyelogram

When poor renal function prohibits the use of intravenous pyelography, or when a survey of such films leaves any doubt regarding the condition of the upper urinary tract, the ureter on the questionable side (or both ureters if indicated) may be catheterized and a radiopaque medium injected.

3. The Cystogram

The filling of the bladder with radiopaque medium through a urethral catheter is used extensively today to test the competence of the vesico-ureteral valves. When these are incompetent, regurgitation of the ureters occurs when the patient voids. It is frequently the cause of recurrent pyelonephritis particularly in children.

4. The Retrograde Urethrogram

The retrograde filling of the urethra with radiopaque medium serves to localize strictures, diverticula, and other abnormalities.

5. Cine-studies of the Urinary Tract

The urinary collecting system is in constant motion, propelling the urine toward the bladder by alternate contraction and relaxation. On the intravenous pyelogram this motion is recorded through the variations in size and shape of the collecting system on the serial films.

A continuous recording is now possible with the recent introduction of an electronic image intensifier. In addition to allowing the urologist to watch these movements, or to perform special procedures under visual con-

trol, they can be recorded on a movie film, projected on a television screen, or both. It is quite evident, at this time, that this method of investigation has opened up a new chapter in urological progress, quite apart from the already recorded achievements is teaching and research.

6. Angiography

The renal arterial system can be visualized by injection of radiopaque medium into the aorta just above the renal arteries. The most valuable contribution of this method is in the investigation of hypertension, when anomalies in the renal arteries may be the basic cause and corrective surgery can bring the blood pressure to normal levels. The procedure also finds a valuable application in the differential diagnosis of renal neoplasms.

7. Retroperitoneal CO_2 Insufflation

The injection of CO_2 into the retroperitoneal space affords an added contrast to x-ray and is useful in outlining enlarged organs and tumors, particularly of the adrenal glands and kidneys.

8. Nephro-tomography

In this procedure the focus of the x-ray tube is varied so that any plane in the body may be chosen for examination, and the adjacent viscera selectively blurred by being out of focus. Its greatest clinical application is in the study of renal and adrenal neoplasms.

E) Evaluation of Bladder Function

Disfunction of the bladder is often found with diseases of the nervous system. At times, notably in multiple sclerosis, a change in the micturition pattern may be one of the earliest manifestations of the illness.

The bladder function can be evaluated by systometric examination where the intravesical pressure is recorded as water is infused into the viscus. When a relatively normal bladder is filled, the intravesical pressure rises to a maximum of 25 cc. of water. It then contains approximately 400 cc. and will empty voluntarily. The abnormal responses to this test fall into several distinct but also overlapping categories.

F) Renal Function Tests

Many tests designed to measure the functional status of the kidneys are available in clinical medicine. Some of these can be done with minimal equipment and effort, while others require more elaborate facilities and care.

1. Urinalysis

A rough estimate of function may be obtained by routine urinalysis. In general, albumin and casts point toward damaged glomeruli, while a high specific gravity suggests good tubular function.

2. Concentration Test

This measures the ability of the tubules to concentrate urine while the patient is maintained on a specific fluid regimen.

3. Phenolsulphonphthalein Test

This is readily performed and is a good index of tubular function.

4. Clearance Tests

The aim of these tests is to express the rate at which the blood is cleared of certain substances by the action of the kidneys. The most commonly used substances are urea and creatinine. The tests are quite sensitive as emphasized by the fact that renal function as measured by the clearance techniques may fall as low as 30 per cent of normal before there is evidence of an increase in the blood urea nitrogen concentration.

5. Radioactive renogram

This is a measure, by external registration, of the inflow, accumulation, and outflow of radioiodinated substances that are subject to a rapid renal excretion. It is employed as a semiquantitative renal function test, but its chief value probably lies in the detection of disparities in functions of the two kidneys.

6. Differential Renal Function Tests

It is often necessary to ascertain the function of each kidney separately. This is obtained by catheterization of the ureters to the renal pelves. Then the PSP test, clearance studies, sodium excretion, urine volume, and urine osmolality can be determined. The differential function tests are employed extensively together with renal angiography for evaluation of hypertension of renal origin.

G) Biochemical Studies

Of the many biochemical tests available in clinical medicine, there are a few that are of special interest to the urologist. These are blood calcium and phosphorus, phosphatases, and uric acid.

1. Calcium and Phosphorus

The chief value of these determinations is to exclude diseases of the parathyroid glands. This is most often manifest in a tumor which produces an excess of parathy-

roid hormone. This leads to increased blood calcium levels and a concomitant decrease in phosphorus concentration. Pathological calcification takes place, and one of the earliest clinical manifestations of the disorder may be renal calculi.

2. Phosphatases

These are serum enzymes of which two can be distinguished. One has greater activity in an acid medium, the other in an alkaline solution. Hence, the names acid and alkaline phosphotase. These enzymes are of chief value in the diagnosis and treatment of prostatic carcinoma. In a certain number of cases the acid fraction is elevated and suggests that the carcinoma has spread beyond the confines of the prostatic capsule. When bony metastases are present, the alkaline fraction may also be elevated. Estrogen treatment and orchiectomy usually have an inhibitory effect on prostatic carcinoma and lower the enzyme values. The latter are useful as controls in patients under treatment for this type of neoplasm, since the levels will tend to rise when the particular form of treatment is no longer adequate.

3. Uric Acid

Renal calculous disease is frequent in patients with an elevated serum uric acid level. The frequency with which calculi form can be markedly lowered by maintaining the patient on a diet low in purines and by increasing his daily water intake.

H) Chemical Analysis of Urinary Calculi

The chemical composition of urinary calculus is frequently dependent on the acidity or alkalinity of the urine. When the urine is acid, calcium oxalate, uric acid, and cystine calculi are formed, whereas carbonates and phosphates are likely to be precipitated in an alkaline urine. In instances where the cause of calculous formation is not known, or cannot be eradicated, such as when both kidneys are scarred from chronic infection, a drug-induced change of urinary acidity together with increased fluid intake may lower the rate of stone formation noticeably.

I) Bacteriological Studies

A definitive treatment of urinary tract infections should not be undertaken before causative factors, such as obstruction and calculous disease, have been ruled out; the offending organism positively identified; sensitivity studies secured. Too often such fundamental principles are neglected. By the time the patient confronts the urologist for the first time the disease has entered a chronic stage with all its dreaded sequelae. The organisms isolated from urinary tract infections are commonly of the gram-negative variety. However, infections with gram-positive organisms do occur as well as infections with Mycobacterium tuberculosis. Although the incidence of tuberculous infections has decreased in this country during the past two decades, it still occurs frequently enough to warrant exclusion of these organisms in many instances of urinary tract infections.

CONCLUSION

The aim of the present-day urologist is threefold. First, he is a strong advocate of early detection and treatment of genito-urinary lesions. In the second place, he supports research in his own and related specialties, hoping that some day in the not too distant future answers may be had to some of the illnesses that today are shrouded in the darkness of ignorance. Finally, he is always willing to perpetuate his knowledge through teaching. He is aware of the lack of trained urologists in some of the less fortunate corners of the world and assists students from such areas in obtaining specialized training that they, in turn, may offer to their own people.

GRADUATES — OTTAWA CIVIC HOSPITAL

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The Role of the Nurse in Investigative Urological Procedures

MARILYN MACDONALD

It is the privilege of the nurse on a urology ward to be of great service to the patient and to the doctor during the evaluation of a patient's condition. To fill this key position and to be a helpful member of the team, the nurse must be well-informed of the "what, when, and why" of diagnostic procedures.

In considering the time spent with the patient during his hospitalization, the nurse outweighs the doctor greatly. She sees and cares for the whole patient. Her observations and descriptions, if keen and accurate, provide valuable assistance to the clinician in his work.

When people are subjected to strange procedures in a strange environment, their cooperation is much easier to obtain if they have some understanding of the reasons why tests are done, and the details concerned with each. Realization that their assistance is essential in providing the physician with accurate results, and that this aids in diagnosis, is usually adequate incentive. The nurse must be prepared to give clear, concise, information to the patient in lay terms, supplementing the doctor's explanation when the situation demands. As a result, many fears will be calmed and natural curiosity satisfied.

Fear and embarrassment commonly trouble the patient who has a urinary tract disorder. Although a layman's concept of anatomy and physiology is vague, he does know that his kidneys are necessary to life; he dreads two things: the possibility of decreased sexual ability and cancer. Patients with urinary incontinence require special skin care because urine in contact with skin surfaces can cause breakdown in a short time. If a voiding pattern can be recognized, an alert, concerned nurse will offer a bedpan or urinal more often than usual, to prevent wet beds and consequent skin damage.

Miss Macdonald is clinical instructor in surgery, Saint John General Hospital, N.B.

Collection of Specimens

One of the most important and most frequent duties for which the nurse is responsible is the collection of specimens. This should be done with a minimum of embarrassment to the patient. The nurse provides the collecting apparatus and specific instructions. She should be aware that collecting bottles must be scrupulously clean, otherwise contamination of the specimen will alter test results.

If urine for culture is desired, the specimen is obtained under sterile precautions. This may involve catheterization, to which many patients object. Strict attention to comfort, both mental and physical; speed, to avoid unnecessary exposure; aseptic technique, to prevent contamination of the specimen obtained and the introduction of infection into the bladder are all essential factors in this situation. To lessen the dangers, a midstream specimen is frequently accepted. For best results, give clear instructions to the patient before collection is started. The genital area must be thoroughly cleansed with soap and water, and the patient voids directly into the specimen bottle, after first passing a small amount of urine. Fe-

males should separate the labia to avoid contamination with urethral and vaginal flora.

When a specimen is collected over a relatively lengthy period (e.g., 24-hour specimen) the patient should understand that a test of quality as well as quantity is desired. If any urine is discarded, results may be greatly altered. A clean collecting bottle is provided for this period, plus a larger receptacle for the total collection. Because urine is subject to bacterial contamination, it should not be allowed to stand at room temperature for more than two hours. If collection and delivery cannot be completed within this time, the specimen should be refrigerated. The patient's help can be accepted many times in collecting urine although the nurse must decide if the patient can be relied upon to carry out instructions accurately.

All specimens must be properly labeled with the patient's name, ward, admission diagnosis, and doctor's name, to prevent any confusion in the laboratory and delay in obtaining results.

In most kidney function tests, it is necessary to collect specimens at a designated time. The nurse must see that the patient empties the bladder and that none of the urine is lost. The required number of properly labeled bottles must be on hand for the necessary specimens.

Tests that require intravenous injection of dye must be carefully explained to the patient so that he is in a relaxed and receptive frame of mind. Following the test, patients are encouraged to drink an extra amount of fluid to help eliminate the remaining dye, and to compensate for withholding fluids prior to the test.

Radiological examinations often bring forth expressions of fear and doubt concerning exposure to x-rays. The patient should be assured that everything possible is done to ensure his safety. Familiarize him with the method of transportation to be employed in his transfer to the x-ray department. Have him properly attired and protected from drafts in corridors.

Since fecal material and gas in the intestinal tract obscure urinary tract structures, as much of this is eliminated before the test as possible. The nurse notes the results of evacuation.

Nursing attention prior to a cystoscopic examination, contributes much to its success. The patient will be more cooperative if well-informed about the procedure. Depending on the anesthetic to be given, fluids may or may not be forced. Explain to the patient that an elongated instrument will be passed into the bladder, through the urethra. Prepare him for some discomfort following the procedure. There may be a sensation of fullness, urgency, or burning, or low back pain.

The nurse has many duties:

1. Maintenance of accurate intake and output records.
2. Strict attention to skin care.
3. Physical preparation of patients before examination.
4. Psychological preparation of patients before examination.
5. Observation and recording of details (pain, voiding pattern, complaints).

The nurse fills an important place on the team. The doctor and the patient both rely on her. Her job demands alertness, awareness and efficiency.

Film Listings

Communicable Diseases

A 30-minute colored film that presents and describes cases of measles, chickenpox, mumps, scarlet fever, whooping cough, etc.

Prevention and Control of Staphylococcal Infections

A 12-minute film in black and white that examines ways in which a new hospital patient may become infected and suggests ways in which this transfer can be prevented and controlled.

These films may be rented by professional audiences — doctors, nursing schools, and other allied groups, from: Canadian Film Institute, 1762 Carling Ave., Ottawa 13, Ont.

TRANSURETHRAL RESECTION

A. E. DUNPHY, M.D., F.A.C.S.

From a technical viewpoint, transurethral resection or endoscopic resection of the prostate is one of the most difficult operations to master. The satisfactory operation and the final result depend not only on the competence of the performer but also on the perfection of the resectoscope.

The improvement of endoscopic procedures parallels the gradual advancement and perfection of the transurethral instruments including powerful high frequency currents. Modern instruments permit rapid excision of tissue and the high frequency currents give instantaneous coagulation of bleeding vessels under a clear view.

Transurethral resection as we know it is a new procedure, but its roots go back to 150 A.D. when Galen first attempted to destroy "callosities" of the urethra by forcing an instrument through the passage. Following these primitive procedures of Galen, blind incision of the bladder neck was performed. Then came the removal of tissue with a punch, and destruction of tissue by fulguration. This led to tunnelling operations in which a channel was bored through the enlarged prostate. The final refinements of modern technique allow complete removal of the prostate gland by the transurethral route. These latter two technologic advances were largely made during the past 30 years in the United States where transurethral resection was more widely accepted.

Indications

As in all operations, one of the clues to successful transurethral resection lies in the careful selection of cases. Endoscopic resection was never meant to supplement open operation but to complement it. Suprapubic, retropubic and perineal prostatectomies all have their relative indications.

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One of the most common indications for the transurethral approach is the benign prostatic hypertrophy of small or medium size. Two extreme schools are found — one advocating endoscopic resection for all benign hypertrophy and the other advising open operation. A more justifiable approach is to suit the operation to the size of the adenoma and to the individual patient.

Other indications include contracture of the vesicle neck, median bar, prostatic tags and cysts of the prostate. In most of these cases there is danger of recurrence, of scar tissue and contraction, but the absence of a proper cleavage plane for enucleation makes the transurethral approach quite acceptable.

Obstruction from advanced carcinoma of the prostate is another indication for transurethral resection. If the malignancy is early, without evidence of metastases, total prostatectomy by the peritoneal or retropubic approach is performed. Most patients with advanced prostatic carcinoma and obstruction should be given a trial of conservative therapy with estrogens and catheter drainage before transurethral surgery is advised. The obstruction may be overcome by non-operative means.

The age and general condition of the patient are also factors to be considered when choosing the type of operation. The older the patient the less chance of recurrence because of the decrease in life expectancy. More consideration therefore is given to the transurethral approach for the older patient.

When complications such as severe renal or heart disease exist and persist despite intensive preoperative treat-

ment, the endoscopic operation is usually chosen.

Operation

Spinal anesthesia is the most widely used anesthetic for transurethral resection of the prostate. Low spinal is probably ideal since the amount of anesthetic necessary to anesthetize the bladder is minimal. In poor risks, epidural anesthesia is desirable since there is less danger of circulatory disturbance than there is following spinal anesthesia.

In no operation is it more important to have all necessary specialized equipment at one's finger tips and in proper working order. In open operations, it is possible to improvise or substitute instruments — a facility which cannot be utilized in endoscopic procedures.

The actual technique of transurethral resection will not be discussed here for this highly technical procedure has so many facets that it is beyond the scope of this short paper.

The amount of prostatic tissue removed in resection of the prostate through the urethral route depends mainly on two factors:

The indications for transurethral resection held by the specific operator which would include the size of the prostate and the amount of obstructing tissue;

to a lesser extent, on the experience of the operator in endoscopic r e s e c t i o n which would encompass the frequency with which it is performed by that particular surgeon. Variable amounts of tissue ranging from 10-50 grams are removed.

Complications

A common misconception held by the laity is that transurethral resection is a simple operation, devoid of complications. The reluctance of the prospective urological patient to accept a "cutting operation" when relief can be obtained through the "harmless" passage of an instrument through the urethra is readily understandable but it has caused considerable difficulty in handling an occasional urological patient. Because of the technical intricacy of transurethral resection, operative complications can be relatively frequent — and at times serious — if the greatest care is not taken. Imperative rules include the using of gentleness in the manipulation of the resectoscope, and a clear visual field with recognizable landmarks discernible. Unrecognized complications may prove dangerous and occasionally lead to a fatal termination.

Most of the complications of electroresection occur during the performance of the operation. Even before the operation begins, difficulty in the insertion of the relatively large resectoscope may necessitate at least an urethral dilatation and, infrequently, urethrotomy. Mechanical difficulties during the procedure can be exasperating at best and make the inspection of all equipment prior to the operation mandatory. Mechanical deficiencies include deficient illumination, inadequate electro-surgical unit, deficient electrodes, connectors, etc.

A more s e r i o u s complication of transurethral resection is perforation and extravasation of fluid from the prostatic fossa. Serious sequellae may result with large quantities of water entering the circulation and causing intravascular hemolysis, water intoxication and cardio-respiratory difficulties. Serious infection may be expected if the areas involved in the extravasation are not properly drained.

Blood loss in open operation is more easily estimated than in transurethral resection. Adequate blood replacement must be available before commencing the procedure. Excessive venous bleeding during the operation, particularly when venous sinuses are open, sets the stage for a complication peculiar to transurethral resection, namely, the *entry of extraneous fluid into the circulation*. The dangers of this complication include cardio-respiratory difficulties from over-loading the circulation, producing fluid and electrolyte imbalances called hyponatremic shock, intravascular hemolysis with its subsequent acute renal failure, and the carrying of bacteria into the circulation if the operative field is infected. The signs and symptoms of these complications do not become apparent in most cases until the post-operative period. The onset of water intoxication (and hyponatremic shock) is heralded by a sudden sharp rise in blood pressure, headache, nausea and vomiting.

A rather unusual, and fortunately

rare, complication of transurethral operations is rupture of the bladder caused either by over-distention of the bladder or from explosion of inflammatory gases produced by the high frequency electric currents. Both causative factors can be greatly minimized by the frequent emptying of the bladder of both the irrigating fluid and the accumulating gases produced by the thermal decomposition of tissue.

Partial removal of the trigone with the danger of destruction of one or both ureteral orifices is occasionally encountered. Damage to the external sphincter with its attendant incontinence may be caused by direct damage on introduction of the resectoscope, or by resection of tissue at or below the level of the verumontanum (the most useful landmark).

Summary

Despite the widely accepted viewpoint that transurethral resection is a minor operation, it is evident that it is a highly technical procedure requiring specialized instruments and a trained operator. Complications in endoscopic procedures can be serious.

Nursing Care in Prostatectomy

SISTER M. PATRICIA *and* LOYOLA C. FLOYD, B.SC.

Principles of geriatric as well as urological nursing must be applied when caring for these patients.

The prostate is an encapsulated gland situated at the base of the bladder where it surrounds the proximal part of the urethra. It is subject to two pathologic conditions that may require surgical intervention : *benign hypertrophy* and *carcinoma*.

As the gland increases in size, it obstructs the prostatic portion of the urethra and therefore interferes with the emptying of the bladder. This results in nocturia, frequent and painful micturition with residual urine remaining in the bladder, or complete urinary retention. The most serious consequence of prostatism is renal damage.

PREOPERATIVE CARE

The patient with a prostatic tumor is admitted to hospital several days prior to surgery. Since he is usually ready to go home ten days after this, the nurse has a relatively short time in which to meet his complete needs. She must follow a definite plan of care if her nursing objectives are to be attained.

Psychological

First impressions are important. On admission, the nurse orients the patient to his surroundings and attempts to put him at ease. She introduces him to other patients in the room, shows him the location of his locker and the bathroom, explains hospital policy regarding visiting hours, etc. She finds out as much as she can about her patient — his likes and dislikes concerning food, his sleeping habits, etc. Such information helps the doctor, nurse and dietitian to understand and care for him as an individual. It also helps the patient realize that the staff are interested in him and eager to be of assistance.

The nurse should be prepared to explain the plan of nursing care, procedures, etc. to her patient. She can answer many of his questions concerning

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his condition but will have to refer others to the physician. It is not uncommon to encounter patients who are very concerned about the possibility of urinary leakage following this type of surgery. Apprehension can be lessened by an understanding staff who take the time to listen and to explain.

Physical

Catheter drainage may or may not be required before surgery, depending on the amount of residual urine in the bladder and the results of the kidney function tests. In either case, urine is measured accurately and a diminished output or hematuria is noted and reported.

Diet should be nourishing, easily digested, and designed to tempt the appetite. Since constipation often troubles patients in this age group, high residue foods are an important part of the diet. Fluids by mouth are encouraged.

A light sedative is administered prior to surgery since heavy sedation increases the danger of postoperative shock in the elderly male.

POSTOPERATIVE CARE

The treatment and nursing care following a prostatectomy have been greatly simplified during the last few years. The patient is taken from the operating room to the recovery room where he is under the watchful eyes of a nursing team until he is fully awake, with blood pressure stabilized.

The control of hemorrhage is the most urgent factor. Blood pressure, pulse and respirations are checked frequently. The retention catheter may serve the dual purpose of draining the bladder and maintaining hemostatic pressure upon the prostatic site. Even with this precaution, bleeding may occur.

Intermittent or continuous bladder irrigations may be ordered depending on the operative method and the surgeon's preference. In some cases, the bladder is not irrigated unless the flow of urine through the catheter is obstructed. Blood clots and pieces of tissue that may cause obstruction are immediately removed by irrigation. Bleeding will cease more readily when the bladder is empty.

During the operation and for the first 24-hour period, the patient receives intravenous fluids and blood if necessary. After he returns from the recovery room, he is encouraged to take fluids orally. The daily intake should be 3,000 cc. — sufficient to ensure a constant passage of fluid over the bladder mucosa.

Fluid intake and output should be accurately measured and recorded. Incontinence should be noted since damage to the external or internal sphincters of the bladder is occasionally a complication of this surgery. If, due to urethral edema, the patient is unable to void after removal of the catheter, it is reinserted for another day or two.

Severe abdominal distention may occur. If it does, a Levin tube is inserted, connected to a suction apparatus and left in place until relief is obtained. Fluids per os are withheld during this period.

The elderly patient who is disturbed if he does not have a daily bowel movement is given a gentle laxative or a Dulcolax suppository on the third postoperative day. An enema is seldom needed since most patients are allowed bathroom privileges on the second postoperative day.

Narcotics should be given as ordered. They do not, however, decrease the contractions of the bladder muscle. The length of time required for these to decrease varies, but most patients obtain relief by the end of a 24-48 hour period.

If the patient complains of unusually severe lower abdominal pain and his bladder is found to be empty, the nurse should gently palpate his lower abdomen. If it is rigid, the surgeon is notified at once since it may indicate bladder perforation. Early detection followed by prompt prevesical drainage seldom postpones recovery for more than one day.

CONVALESCENCE

It is important for the patient to realize that the process of recovery is gradual. Even if he is discharged without complete bladder control, his chances of eventually attaining this are good. He should be told that his sleep may be disturbed by urinary frequency for about a month. On discharge he should be instructed :

To contact the doctor at once if bleeding should occur;

to avoid vigorous exercise for about three weeks;

to maintain an increased fluid intake for at least a month.

The convalescent stage is a most important period if the return to normal health is to be accomplished in the least possible time. The good results of surgical treatment may be seriously interfered with if the patient is not carefully instructed concerning his future activity and physical care.

RENAL FAILURE

WILLIAM H. LAKEY, M.D.

A discussion of the causes, signs, symptoms and management of acute and chronic renal failure.

Renal failure indicates that the kidney has lost its ability to excrete the waste products of the body's metabolism. In acute renal failure the kidneys excrete small volumes of urine following a severe insult to the kidney tissue. The development of chronic renal failure usually develops over many months or years as progressive destruction of the nephrons occur and the kidney becomes less and less efficient.

Acute Renal Failure

This is a reversible lesion of the renal parenchyma which is manifest by a 24-hour urine output of less than 400 cc. The tubular epithelium is damaged, the body's waste products accumulate in the blood stream, and the clinical picture of uremia develops. Other terms used to describe this condition are: lower nephron nephrosis, acute tubular necrosis and acute renal shutdown.

Etiology

This disease may be caused by the shock associated with burns, severe wounds, crushing injuries or extensive blood loss. The diminished blood flow to the kidney during this period results in renal tubular necrosis and diminished urinary output. Incompatible blood transfusions, intravascular hemolysis resulting from administration of intravenous distilled water, and nephrotoxic substances such as bichloride of mercury or carbon tetrachloride may also produce necrosis of the tubules.

Dr. Lakey is Assistant Professor of Surgery, University of Alberta, Edmonton.

Clinical Picture

The striking feature is oliguria or a urinary output of less than 400 cc. Severe cases may develop anuria or less than a one-ounce urinary output per day. Obstruction to the urinary tract must be ruled out. With the onset of uremia, the patient may develop muscular twitching, mental and physical weakness, pruritus and nausea with vomiting. The rate of rise of the blood urea nitrogen is determined by the amount of tissue damage occurring in the body. If excess fluid has been administered to the patient, he may reveal signs and symptoms of cardiac failure such as pulmonary edema, cyanosis, dyspnea and peripheral edema.

Management

During the oliguric phase, attempts are made to minimize the effects resulting from the virtual absence of renal excretion and, secondly, to pro-

vide some artificial means to eliminate the waste products. The objective is to maintain life until regeneration of the renal tubules has occurred and satisfactory renal excretion can take place.

1. *Fluid Intake:* This must be rigidly controlled so that it equals 400 cc. plus the amount lost through urinary output, nasogastric suction or diarrhea. Daily weighing, although often a difficult nursing task when it involves a seriously ill patient, is a useful way of determining whether or not excess loading of fluid is occurring. The 100 gm. of carbohydrate given to such a patient generate 400 cc. of water of oxidation, which, when added to the 400 cc. intake allowed, replenishes the 800 cc. loss by perspiration, breathing and other forms of insensible loss. The regulation of water intake forms the most important aspect of care in the management of acute renal failure patients. Prior to our better understanding of the pathophysiology of this disease, these patients were literally over-loaded with water.

2. *Electrolytes:* Elevation of serum potassium, which occurs with inadequate renal excretion, and the excess release of this ion from tissue cells as they are destroyed, present other problems of care. The use of the sodium cation exchange resins, given in a retention enema, aids greatly in the lowering of the serum potassium level. The complex molecule of this resin allows the easy transfer of a potassium ion for a sodium ion through the contact it achieves with the blood in the mucosa of the rectal wall. For the rapid lowering of a very high serum potassium, an infusion of insulin in glucose will be temporarily effective. As glycogen is formed in the liver from glucose, potassium ions are taken from the blood stream and the serum level is lowered. The hyperkalemia or elevated serum potassium has its major effect on the heart muscle. When the level rises above 8 m.Eq./1., there is danger of cardiac arrest.

3. *Nourishment:* This must be provided in the form of carbohydrates. Proteins cannot be used since they are broken down to more urea and uric acid to further elevate the blood levels. At least 100 gm. of carbohydrate are given each day in the form of intravenous solutions or oral glucose. A weight loss of one pound per day should occur if the fluid and nourishment are being regulated correctly.

4. *Anemia:* This may develop during the oliguric period, thus requiring transfusions of packed red blood cells.

5. *Infection Control:* These patients are particularly prone to infections. Prophylactic antibiotic therapy may be necessary.

Hemodialysis

The artificial kidney provides a means of lowering the blood level of urea, creatinine, uric acid and potassium. The semipermeable membrane or Cellophane separates the patient's blood stream from the dialysate or bath solution which contains the ideal concentration of serum electrolytes. The difference in concentration of these waste materials accumulated on the blood side results in their movement through the pores and their elimination from the patient's blood stream. By increasing the pressure on the blood side, excess fluid can also be forced from the blood into the bath solution. The blood is taken from the patient via the radial artery and returned into the antecubital vein. The Kolff Twin Coil Kidney has been the most popular in the care of acute cases of renal failure because of its ease of assembly and efficiency. Patients require two or three, four-hour hemodialyses during the 14 to 21 days of oliguria.

Chronic Renal Failure

Progressive destruction of the functioning renal parenchyma results in the eventual development of chronic renal failure. Initially there may be some reversibility to the disease process, but eventually it will become an irreversible destruction. The uremic state then becomes a clinical problem.

Etiology

Although there are many causes, most cases seen in clinical practice result from chronic pyelonephritis, chronic glomerulonephritis, polycystic kidneys or hydronephrotic damage. A great deal of the renal parenchyma must be destroyed before renal failure supervenes. Compensated renal failure may be compatible with many years of life and the prognosis depends on the rate of destruction of the kidney tissue.

Clinical Picture

The clinical features of the patient may consist of a normochromic ane-

mia, lassitude, loss of weight and hypertension. The late signs include skin and gastrointestinal bleeding, muscular twitchings, uremic convulsions, pericarditis, Cheyne-Stokes breathing, ulceration of the mouth and fetid breath.

Management

The management of such patients has been discouraging in the past. The restriction of protein intake and the regulation of the salt requirements has helped to prolong the inevitable terminal uremic coma. Hemodialysis with artificial kidneys has also helped to extend life. Perhaps one of the most promising techniques for the long-term care of the chronic renal failure patient has been the one developed recently by Dr. Belding Scribner at the University of Washington Medical School, Seattle. Plastic arterio-venous cannulas are inserted into the forearm of the uremic patient to provide an arterial outflow and venous inflow for attachment to an artificial kidney. The cannulas are joined by a by-pass cannula to keep them patent when hemodialysis is not occurring. The plastic cannulas have been surprisingly effective in maintaining a constant source of blood for hemodialysis. The particular artificial kidney used requires no priming with blood and can be monitored by a graduate nurse. With a weekly or biweekly hemodialysis, the patient can lead a relatively normal life, keeping a blood urea nitrogen in the low range. As long as the arterio-venous shunt can be maintained and is functioning well, the patient can be kept alive and relieved of the signs and symptoms of uremia. This technique is currently being evaluated and used by staff members at the University of Alberta Hospital, Edmonton.

The ideal management would be the transplantation of a donor kidney to the uremic patient. Until an infallible method of preventing the usual rejection of the kidney by the host can be found, this technique is experimental.

Coming!

IN

OCTOBER 1963

Long — Changes in Nursing Education in Saskatchewan

Crispo — Collective Bargaining and the Professional

Laws — Crossed Eyes—The Modern Approach

Ford — Johnny, A Deliquent

Young — Jennifer Learns About Diabetes

MacKay — Twins

plus additional material

Blind men are considered more cheerful than deaf men, because it is when conversing with friends that they have their happiest hours. Necessarily, no one sees their sad times, for those come only when they are alone. With a deaf man it is the reverse. In company he is at a disadvantage, and so many seem aloof or morose. Alone, enjoying his books, some sport or a view, he can be as happy as anyone else. — LORD GREY

Postoperative Care Following Nephrectomy

NANCY CHRISTOPHER

The end result of this surgery depends upon the quality of nursing care given.

Postoperative care begins immediately following surgery when the patient is ready to be transferred from the operating table on to the recovery bed. During this procedure he should be lifted so that all parts of his body are supported and in good alignment. In the recovery room he must be carefully and constantly observed until fully conscious. This involves the maintenance of a patent airway, prevention of the aspiration of mucus, checking of the vital signs as well as noting the presence of drainage or blood through dressings and drainage tubes.

When the patient has been returned to his room, the same check is carried out. Operating room clothing is then removed, hands and face are washed, and mouth care is given. He is placed in a comfortable position with pillows used for support as necessary. Side rails should be placed in position if the patient is not yet fully oriented to his surroundings. If his condition permits, a short visit from a member of the family will help to provide reassurance.

Prevention of Complications

Special nursing measures are necessary for persons who have had a flank incision. Because this incision is directly below the diaphragm, the patient is reluctant to take deep breaths, to cough or move about. The development of atelectasis or hypostatic pneumonia is thus a distinct possibility. The patient must be encouraged to expand the rib cage fully by deep breathing, coughing at least every two hours, and by turning frequently from side to side. Support should be provided to the affected side. Medication should be given as ordered to relieve pain and to allow the patient to carry out his postoperative exercises more easily.

Clots in the veins of the lower extremities may form due to retardation of venous flow, increased coagulability of the blood, or inflammatory changes in the walls of the veins. This is a result of muscular inactivity, postoperative respiratory and circulatory depression, and increased pressure on blood vessels due to tight dressings, intestinal distention or prolonged maintenance of a sitting position. Exercises and early ambulation must be initiated to prevent this complication as soon as possible after surgery. The patient should be taught to bend his knees, to lower them, and to contract and relax his calf and thigh muscles at regular intervals, with rest periods in between. The bed linen should always be arranged to facilitate movement. As soon as possible the patient should be ambulatory. Adequate support is necessary to prevent pull on injured muscles and to help reassure the patient.*

Hemorrhage may occur within the first 48-hour period or as late as eight

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to twelve days postoperatively. Evidence of bright red blood on dressings is a sign of danger. A fall in blood pressure, an increase in pulse and respiration rates, pallor and restlessness are also signs which should be reported immediately.

Abdominal distention is common following a nephrectomy. Gas accumulates in the intestines as a result of pressure on the bowel during surgery, swallowing of air during recovery from anesthetic and from transudation of gases from the blood stream to the atonic portions of the bowel. As the unaffected parts of the bowel contract in an attempt to pass the contents along, gas pains occur and can cause a great deal of discomfort. If the distention is high, due to stomach dilatation, the patient may experience difficulty in breathing. A Levin tube may be passed to aspirate the stomach contents. A rectal tube may also prove effective in removing gas from the bowel. The tube should be well-lubricated, inserted just beyond the rectal sphincter, and removed after 20 minutes. Small carminative enemas may be ordered by the doctor at intervals until peristalsis occurs. If bowel sounds remain absent after 48 hours, a paralytic ileus is suspected. In this case there is complete absence of bowel tone. The patient is kept fasting and gastric suction is continued until peristalsis begins.

Care of Incision

Some patients are reluctant to move about or to get out of bed for fear of causing the sutures to break. A great deal of reassurance is essential. The patient should be told why drainage tubes are being used so that he will not be unduly alarmed at the sight of drainage on his dressings. Only serosanguineous drainage should be expected; any abnormal amount or change in consistency should be noted. If there is a large amount of drainage, frequent change of dressings will be necessary to keep the wound dry, and to make the patient comfortable. Drainage tubes are usually shortened one to three inches daily, after the third day, until removed. Care must be taken in shortening drains to insure that the pin is safely fastened before the drainage tube is cut thus preventing it from slipping back into the incision. Sutures are removed on the eighth to tenth day, with the doctor's permission. Wound infections may be suspected with complaints of continuous pain in the incision, low grade fever or edema in the surrounding area.

Intake and Output

A patient who has had a nephrectomy should receive a high fluid intake. Parenteral fluids may be ordered until he is able to tolerate fluids orally. If vomiting occurs, electrolyte balance may be disturbed. Blood chemistry estimates of serum sodium, potassium, chlorides and CO_2 combining powers are made to determine the extent of this imbalance and to aid the doctor in replacing losses. Urinary output should be measured at frequent intervals. Any sign of urinary suppression or renal failure resulting from shock or as a reaction to the anesthetic should be reported at once. The importance of accurate charting is obvious.

Preparation for Discharge

Health teaching regarding home care should begin several days prior to discharge. It is a wise plan to have a member of the patient's family present while the most important points of care are being discussed.

* Shafer, Sawyer et al, *Medical-Surgical Nursing*, St. Louis, C.V. Mosby Co., 1961, p. 152.

The problems of deafness are deeper and more complex, if not more important, than those of blindness. Deafness is a much worse misfortune for it means the loss of the most vital stimulus, the sound of the voice that brings language, sets thoughts astir, and keeps us in the intellectual company of man. — HELEN KELLER

* * *

Educate men without religion and you make them but clever devils.

— DUKE OF WELLINGTON

PATIENT EXPECTATIONS and the PATIENT ROLE

DAISY M. TAGLIACOZZO, PH.D.

Most patients attempt to conform to the demands of institutional care. Does this adjustment contribute to the therapeutic goals of such care?

Notable changes have taken place in the organizational role of the professional nurse. Yet, evidence suggests that the hospitalized patient continues to expect from a "good" nurse many of those attributes which are associated with her *traditional* role. This orientation may persist in part because traditional images of widely recognized roles change but slowly. It may also persist because patients, similar to people in many other situations, cannot expect specific activities and, instead, focus on those attitudes and sentiments which communicate general adherence to the values and purposes of an important role. From the point of view of the patient, these values and purposes are unchanged; they involve the care and cure of the sick.

The research data upon which this discussion rests demonstrates forcefully that hospitalized patients react with great sensitivity to the personality and attitudes which they infer from the behavior of nurses.*

THE "GOOD" NURSE

When patients were asked what they *ideally* expected from a nurse, they mentioned specifically a "kind and friendly personality," a "cheerful (smiling) personality," "knowledge of the patient," "dedication," "spontaneous services," and a "fast response" to their calls for a nurse. Patients also emphasized that nurses "ideally" should give the sick "some encouragement," should have "patience and tolerance" for more difficult patients and "enough time" for those patients whose illness demands more attention of a nurse.

When these expectations were combined into more general categories, it was found that 81 per cent of the respondents stressed the importance of *personalized* care; 81 per cent also emphasized *personality attributes* and 45 per cent expected *prompt and efficient services*. Fewer patients — 29 per cent — mentioned specifically that they expected knowledge and technical skills. Other attributes took priority in the thinking of these patients and evidence of knowledge and skillful nursing care was inferred from their perception of appropriate sentiments and motivations.

In other areas of discussion, the orientations were consistent with these ideal expectations of patients. The emphasis remained essentially the same when patients were asked how they identified a good nurse and when they were asked to describe who should become a nurse. In answer to the last question "dedication" and "interest in the patient" were most frequently mentioned as desirable attributes.

Dr. Tagliacozzo is Associate Professor of Sociology, Illinois Institute of Technology, Chicago. She presented this address at the annual RNAO convention in Toronto.

* In a research project at Presbyterian-St. Luke's Hospital, Chicago, 132 verbatim recorded interviews with 86 patients were analyzed in order to formulate hypotheses about the meaning of the patients' expectations of nurses. The sample was divided between male and female patients with cardiovascular and gastrointestinal illnesses. All patients were between 40 and 60 years old, married and all have had previous experiences with hospitalization. All patients were American born, Caucasian.

tioned as very desirable attributes.

Ideal expectations represented more than idealized descriptions of nurses or nursing care. The same standards guided, for example, what patients would spontaneously recall from past hospitalization. Over half of them remembered vividly those nurses who responded to them with interest and kindness. Many also recalled experiences which illustrated the absence of such desirable care. The same standards were also applied to the evaluation of current hospitalization. Patients reacted with praise to any evidence of personalized care, to any sign of kindness and to promptness and efficiency. They criticized a slow response most frequently but also reacted negatively to any behavior that seemed to be lacking in friendliness or interest in the patient.

Many patients expressed their awareness of the changing responsibilities of the professional nurse. Such an awareness was most often reflected in the intensely grateful reactions to nurses who met their expectations. From the point of view of these patients, good nursing care was provided with some difficulties because nurses were obviously harassed and "burdened with a lot of paper work." Yet, in spite of the recognition that it was difficult for nurses to meet their expectations, patients persisted in guiding their observations and reactions in accordance with their ideal standards. These standards determined what they selected as significant and meaningful and the resulting conclusions often seemed to affect the adjustment to hospitalization.

An understanding of patient-expectations is facilitated by relating them to the efforts of patients to find, in the environment of the hospital, evidence which denies their fears, which confirms the presence of reliable care and which facilitates the patient's task to express himself with a minimum of risk of disturbing his relationships to nurses and physicians.

It was apparent during the interviews that some patients were profoundly disturbed. Some of them cried once they were given an opportunity to talk about their concerns; others relieved their tensions in aggressive criticisms of care and cure procedures. The often intense demand of these patients for "kind nurses," for "interest and some sympathy" appeared *symptomatic of their impaired capacity to cope alone with a threatening experience*. Many of these patients had been or still were severely ill.

The majority of patients in the sample was, however, not severely ill at the time of the interview. Most of them did not give evidence of emotional disturbance or intense concern with the nature or consequences of their illness. By and large, they were satisfied with the care they received. Yet, while these were not "problem patients," their adjustment to hospitalization was occasionally disturbed. The strains which many of these patients seemed to experience periodically appeared to be the consequence of, at times, too strenuous efforts:

to submit to the assumed expectations of nurses and physicians;

to accommodate demands to the assumed needs and problems of nurses, physicians and other patients;

to make an effort to gear self-expressions to what was considered to be proper behavior and to what were feared to be the consequences of improper demands.

Many of the ideas which these patients had of the modern hospital developed prior to hospitalization. They had learned about some problems of large-scale organizations, about the financial problems of hospitalization, about a shortage of skilled nursing personnel, and about widely publicized errors in care and cure procedures. Some of their friends had exposed them to stories about their more dramatic experiences during hospitalization. Thus, many of these patients came to the hospital with some doubts and apprehensions.

The more apprehensive patients found their preconceptions confirmed in many direct ad indirect ways. *Long waiting periods and casual comments* by those who took care of them confirmed their opinion that there was a shortage of skilled personnel. Over 90 per cent of the patients in the sample observed that nurses and physicians are overworked and rushed. This observation made many patients hesitant to "take their time" for anything but the most urgent matters. The same

observation also intensified gratitude and a sense of obligation towards those who showed an interest in the patient in spite of the fact that it was so obviously difficult for them.

The widespread admiration for the overworked functionaries of the hospital did not eliminate widespread concern with possible mistakes in care procedures. This risk, considered inescapable by many patients, was magnified for those who reacted also to the relatively impersonal nature of care, to the constant change of personnel and to the infrequent presence of the head nurse. Some patients also reacted apprehensively to the abundance of less skilled personnel and to the intensity of activities as conveyed by sound and motion.

A concern with the possibility of mistakes was expressed in many ways during the interviews. It found expression in the nature of the memories of significant episodes during past hospitalization, in discussions of the needs of patients, in the reasons that were given for some expectations of nurses and in the intense preoccupation with apparent irregularities in care procedures.

A patient was upset because, from his point of view, the specimen ordered by his doctor should have been picked up sooner; another patient was concerned because the color of his medication had changed without apparent reason. One patient was upset because an aide had not washed her hands after manipulating a bedpan, and another — to mention only a few of the many examples — was concerned because his medication was administered somewhat later than ordered by his physician.

Patients were most outspoken when they discussed the needs of other patients. Here, the demand for safety, for efficient and prompt care procedures, stood second in importance only to the demand for interest and attention. Without being specifically questioned, 45 per cent of the respondents stated that other patients need to feel that they are protected from "negligence" and "confusion."

THE "GOOD" PATIENT

Many patients admitted that they were reluctant to reveal to nurses or physicians their apprehensions or dissatisfactions.

Some patients refused to discuss with anyone their fears of cancer or other serious illnesses and others were not ready to express to nurses their desires for certain services — for instance, a back-rub. One patient was upset because he had heard the word "tumor" when listening to a discussion between physicians, but he was unwilling to ask any questions. Again, a female patient admitted to the interviewer that she was upset because she did not like "the expression" on her physician's face; and another was convinced that her condition must have deteriorated because more than one physician came to examine her. Several patients had reacted with irritation to "the manners" of individual members of the nursing staff.

None of these patients had attempted to seek support, clarification or to express a negative reaction. Sixty-eight per cent mentioned that they had refrained from expressing their desires, fears or criticisms. When explaining this reluctance, the majority stressed the obligation of a patient, over and above the privileges of a paying consumer and over and above the prerogatives of a sick person. The emphasis of these patients was on self-control, on a minimum of dependency, on being "cooperative," "undemanding" and "considerate." Patients were most eager to interject into the interview self-descriptions which confirmed their conformity to these standards. When they were asked to describe themselves on any attributes, they were guided by the desire to appear to others as "good" patients. They described themselves as grateful, confident, trusting, cooperative, considerate and not demanding.

Respondents were not only eager to present themselves as "good" patients; they also were convinced that nurses expected such behavior from them. Thus, when asked what nurses expected of them, 66 per cent felt that they were expected to cooperate, 38 per cent believed that they should be constrained in their demands, 33 per cent felt that they should show respect and 26 per cent thought that they were expected to be considerate. In spontaneous discussions of their obligations, 52 per cent stressed not being demanding or dependent, 56 per cent mentioned being cooperative and 30 per cent spoke of the obligation to be considerate.

The eagerness of patients to present themselves as "good" patients was motivated, in part, by gratitude and admiration for the "overworked and rushed" nurse and physician. It was also prompted by self-interest because patients emphasized the relationship between cooperation and recuperation. But these attitudes also expressed the *insecurity* which restrains the uninitiated lay person in his relationships to competent, professional personnel.

Insecurity not only prevented many patients from assessing adequately the quality and correctness of care and cure procedures, it also prevented them from determining without doubt what care procedures were, in their cases, really necessary rather than merely desirable. Such judgment was important to most patients because they believed that legitimate claims derived from the degree of severity of their illness. Being a paying client entitled them to no more than room and board. All other services depended on "how sick you really are." Other patients, who demanded more than their illness seemed to justify, were criticized for being too demanding and inconsiderate. However, many of them were not quite sure what they could legitimately demand without going too far. The urgency and real necessity of their own demands were also thrown in doubt when they observed other, possibly sicker patients.

The "good" patient restraint was further enhanced by a realistic awareness of his dependency on hospital personnel and of his powerlessness in affecting the course of events during hospitalization. Adherence to the expectations of nurses was of particular importance to those patients who feared that any deviant behavior would be followed by negative sanctions. Some of these patients were convinced that good services were more readily available as long as you succeeded in making yourself acceptable to members of the nursing staff. Some patients presented such ideas as matter of fact observations:

> I've been around a long time. I have learned that you can't go expressing yourself under any situation. You can't, unless you hire someone who is going to listen to you and won't kick back... It doesn't pay to make enemies anywhere. If they see their button light up, they could just keep you waiting. They could make the bed poorly.

Other patients observed more sympathetically that nurses were "only human" and "naturally would not like to look after you if you are demanding and complaining."

The assumed power of nurses to sanction the behavior of patients was resented by some. Such resentment was typically reflected in the refusal to talk to nurses because one would not want to "get all upset," because "talking to anyone around here is futile," or because the patient felt that he was "at their mercy." The following quotation illustrates this orientation:

> I don't want to get into trouble with any of them. All they have to do is not to answer your bell. I don't care how bad you are hurt. If you are crying or if you are in pain — they still can refuse to answer your bell.

Fears of displeasing others appeared to intensify for patients who felt dependent on a fast response to their calls and who feared to be left alone during a sudden, unanticipated crisis. Some of these patients refused to verbalize less urgent requests in the hope that they could secure for themselves reliable services when the "real need" arose. They tried, as one patient expressed it, to "save that button" in the hope that any call for a nurse would be interpreted in the light of their past, restrained behavior. This attitude was typical of patients having coronary conditions.

The expectations of patients for pleasant personality attributes, for personalized care and for prompt and efficient services, are better understood in the light of the preceding orientations. The attitudes and reactions of patients which compel compliance with expected behavior — be they insecurity, gratitude, fear or strategy — also intensify the desire of patients to be approached by those who take care of them. The "good" patient is reluctant to seize initiative. His desire not to disturb the equilibrium of significant relationships results in the hope that he will obtain services without having to ask for them. Thus, patients expect that services be given

"spontaneously," that the nurse "knows the patient's case well," that she "takes a personal interest in the patient," and "asks him what he needs."

I'd say what would make a good nurse is anticipating a patient's needs. Not waiting until they are needed, but trying to anticipate it — which you cannot do all the time. But there are certain things that one can, I imagine, anticipate.

The "nice" nurse with the "pleasant personality" also makes it easier for patients to seize initiative and to express their feelings and reactions without fear. She makes the task of being a "good" patient less difficult:

You feel that services are rendered willingly, not grudgingly. In fact, you do not feel so much like a burden.

The conditions which caused such profound changes in the functions of the professional nurse also contribute to an intensified demand for those modes of care which are increasingly more difficult to provide. Patients reacted repeatedly to the *impersonal nature* of hospital care. The smile gained, at least in part, so much significance because it established some relatedness and communicated interest in and recognition of the individual patient. Influenced by their culture's sharp distinction between physical and emotional needs, patients repeatedly emphasized that legitimate demands stem only from physical needs and that the hospitalized patient must "cope alone with his emotional problems." Other reactions, however, reflected the difficulties which some patients had in adhering to this principle and in accepting the consequences of purely physical care:

You're no more a patient but just a number. You dare not ask a question. You know they are too busy. If they come around, fine, that's it — we'll see you next time — and that's it.

The relatively impersonal nature of care procedures also seemed to intensify the concern with mistakes and organizational confusion. This concern finds expression not only in the expectation for a prompt response to the patient's call; it also was expressed in the desire for personalized care. From the point of view of many patients, mistakes can be prevented if nurses know their patients and if they take a personal interest in them. Many patients emphasized that their confidence increased when they could observe such attitudes. Often they appeared to be victims of first impressions. These first impressions cause patients to relax or, conversely, to become anxious and distrustful observers for the rest of their stay in the hospital:

They come in and introduce themselves and ask you how you're feeling and that helps you a lot. If somebody just comes in there and just looks at you and walks out — why, it seems that they're not part of you or trying to help you. I think that being pleasant is a big factor to their office and asking your name is another thing that's important — maybe somebody gave the wrong medicine or something had gone wrong in the hospital. I don't know why that started.

Those patients who were convinced that modern patient care was impersonal and that hospital personnel did not have a real interest in the individual patient invariably expressed a more intense fear of mistakes and neglect:

I really feel that the nurses do not care personally for the individual patient. You don't get that feeling of personal interest. I think you feel badly because even though you may be wrong, you feel that something may happen to you . . .

A prompt response to a patient's call belonged to the concretely most important and symbolically most meaningful services. Patients described how a slow response can intensify physical discomfort and how it can trigger anger because the patient is made to feel helpless and dependent. Their reactions to being kept waiting, for example, for the removal of a bedpan, found expression in spite of repeated efforts to stress that they try to keep in mind that nurses may be "busy with more important things." In addition to these more obvious frustrations, a prompt response was also important because it communicated to many patients that they can rely on nurses, that there was an interest in them and that even

"unpleasant tasks" were carried out willingly. A slow response, on the other hand, often became the starting point for diminished trust in the reliability of all care procedures. It intensified latent resentment and often constituted "proof" that the patient's demands were not taken seriously. Many patients admitted that they were not sick enough to suffer seriously from the consequences of a slow response, but they also admitted that the implications made them apprehensive:

You ask yourself: "What will happen to me if I am really sick, if I'm really in a serious condition ?" You might be abandoned . . . I've seen it happen on different occasions to others . . .

DISCUSSION

Many questions were directed to Dr. Tagliacozzo:

Q. Did the respondents comment upon the role of auxiliary personnel ?

A. Yes — and most of the remarks were favorable. The nursing assistant was described as more personal, less rushed, and under less pressure. When the patient was *very* ill, however, she became apprehensive when too much of the care was provided by auxiliary staff.

Q. Was any distinction made by respondents between the graduate and the student nurse ?

A. Yes. The study revealed that most patients love student nurses because they are less distant than graduates and give warmer, more personalized care. Other studies indicate that psychological reactions to suffering do occur in nursing. These result in certain defences arising within the practitioner.

Q. Were the comments expressed influenced by the respondent's sex ?

A. Yes. Female patients were more critical than male patients of the nurses and nursing. One possible reason for this is that women show less restraint in expressing themselves and feel freer to be dependent and more demanding. They may also feel that they know something about nursing — how to make beds, etc. — and therefore are more critical.

CONCLUSION

Hospital functionaries can anticipate that most of their patients will make every effort to conform to the demands of institutional care. However, the data suggests that the "good" patient's adjustment to stress may not always contribute to the therapeutic goals of patient care. The desire of patients to conform to what they perceive to be expected behavior tends to interfere with effective communication. It is not easy to know a "good" patient unless he is encouraged to respond as a "sick person." Unless active steps are taken to change the patient's definition of the situation, nurses cannot take it for granted that the patient will reveal his needs or that he will seize initiative in obtaining the care which he desires or needs.

Some of the difficulties which patients experience during hospitalization are not solely the consequences of modern modes of patient care. Patient care in large organizations may be impersonal. However, the distance between patients and those who take care of them is also intensified by attitudes which were shaped within a much broader social framework. Those who work with the hospitalized patient will also have to be sensitive to this cultural bias."

The data suggest that the behavior of patients is, at least in part, a function of their preconceptions and reactions to hospital reality and not solely a result of "emotional disturbances." Because of their inability to control the professional expert, patients feel realistically dependent. They cannot easily judge the presence or absence of efficiency, competence and reliability; if they do they may continue to feel insecure in their judgment. They cannot clearly observe care and cure procedures — they can at best gain impressions. If they are dissatisfied, they have few means of control and they often find it difficult to place responsibility beyond doubt. If they refuse to cooperate they threaten to harm themselves. Their self-assertion as paying consumers is made difficult because of their moral commitment to other sick patients and to those who dedicate their life to an obviously difficult task. Thus, they try to tie their demands to an often barely understood condition — the severity of their

illness. This vague means for legitimizing claims makes it more likely for patients that they may go too far, that they may ask for more than they are entitled to. In every social situation such violation tends to imply a risk. To those who feel that their health may depend on securing good care, efforts to avoid such deviations from acceptable behavior can appear as logical and necessary.

Generally, the easier it is to obtain from people conformity to expectations, the more such conforming behavior may come to be taken for granted. The data suggest that the "good" patient deserves attention and that attempts to alleviate some of the tensions which patients experience may have to go beyond a selective focus on the acting-out "problem" patient. Thus, dealing with the concern of patients with their safety can lead to consideration of physical arrangements, to a concern with various ways of assuring the patient that his physician's orders will be carried out, that he can count on a prompt response during periods of crisis and to a concern with various modes of communicating a knowledge of and interest in him. The belief that nurses are too overworked to give the patient anything but what is absolutely necessary may have to be actively corrected. Nurses may have to play a more active part in clarifying to the patient what he can demand without fearing the consequences. The attitudes of patients do not suggest that many patients would be prone to exploit such encouragement.

ABOVE AND BEYOND THE CALL . . .

MURIEL EVANS

On the evening of May 27, 1963, AUDREY JAKEMAN, a district nurse at Trout River, Newfoundland was presented with the Humane Society's Certificate for bravery and credited with saving a patient's life. This was the final chapter in a story which began on January 23, 1962.

A patient in Miss Jakeman's district was in need of medical attention. Preparations were made to take her to the nearest hospital 12 miles away. She was placed on a horse-drawn sleigh and the party consisting of the nurse, the patient's mother and five men from the settlement set off to walk through the mountainous area. Another person was sent to telephone the settlement at Woody Point that the party was on its way. Unfortunately, the telephone wires were down and authorities could not be notified, but the people accompanying the patient did not know this.

It was 3:00 p.m. when the group set off. The weather was fine; everything started well for the journey which normally takes 5 hours. Half-way to Woody Point, the weather changed and a blizzard blew up. It became so stormy that it was extremely difficult to find the road. One of the horses collapsed and died. It became increasingly apparent that the situation was critical. After consultation it was decided that two of the men should go ahead and try to contact the party which they hoped had set out from Woody Point to meet them. The wind had an estimated velocity of 70-90 miles per hour; the temperature was 15-20 degrees below zero. In order to keep the patient warm and to prevent the blankets from blowing off, Miss Jakeman stretched out on top of the sleigh.

The two men who had set out for Woody Point eventually arrived at the settlement; a group of helpers was quickly summoned. When the rescuers reached the group huddled on the mountainside, Miss Jakeman was still protecting her patient and had maintained her position on the sleigh in the howling blizzard for six hours. The party eventually reached Woody Point at 1:00 a.m.

Miss Jakeman came to Newfoundland in 1953 and during the past 10 years she has worked as a public health nurse and midwife in the Trout River district.

Miss Evans is field consultant with the Departmental Nursing Services, Department of Health, St. John's, Nfld.

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

SCHOOL IMPROVEMENT DIRECTOR PLEASED WITH WORKSHOPS

GLENNA ROWSELL, director of the CNA School Improvement Program has now completed nine of the 22 workshops being held across Canada to study essential principles in developing objectives in basic nursing education programs. She is delighted with the response she has received. "All schools have been working very hard since I saw them a year ago," she said, "and the larger attendance at all workshops this year is significant, I think, of the interest in the program."

Miss Rowsell started out from National Office last March for the first of the three-day conferences in Halifax, where she had a registration of 32 Nova Scotia nurses. Miss JEAN WILSON, associate professor of the school of nursing at the University of Toronto was the consultant at the Halifax workshop as well as at the one in Sydney which followed later in the month with 27 nurses in attendance. In April, Miss Rowsell travelled to Fredericton and Quebec City. Miss ELLA M. HOWARD, director of nursing at the New Mount Sinai Hospital in Toronto, was the consultant in Fredericton where 35 nurses registered, and Miss GABRIELLE CHARBONNEAU, director of the school of public health nursing at the University of Montreal, acted as consultant to the Quebec conference attended by 55 nurses.

Miss Rowsell then moved west to British Columbia where she welcomed 90 registrants to Vancouver and Victoria, and was joined again by Miss Howard as consultant. Not only did these two workshops draw a large attendance, but they also drew wide press and television coverage, as did the next workshop in Winnipeg. Eighty nurses attended in Winnipeg where Mrs. JEAN DALZIEL of the Registered Nurses' Association of Ontario was the consultant. Miss ANNA A. CHRISTIE, educational consultant for schools of nursing in New Brunswick, was the consultant to the workshop which opened in Montreal, June 24. Here again, 80 nurses were in attendance. The ninth workshop was held in Charlottetown with Miss ALMA REID, director of the school of nursing at McMaster University, as consultant.

Miss Rowsell points out that letters received from those taking part in the workshops indicate how extremely helpful the program is. Later this month Miss Rowsell will be back in Montreal for the French workshop.

STILL IN THE NEWS

In a recent issue of the Toronto *Globe and Mail* we find that the craft centre operated by PENNY STIVER and CHRISTINE LIVINGSTON is proving popular with U.S. tourists, so much so in fact, that Miss Livingston had to make a hurried trip to Quebec to replenish their depleted stock. We were sure all readers of *The Canadian Nurse* would be delighted to hear this and to know that they are enjoying the shop so much.

Why Another Questionnaire?

A few issues back, you will recall a double-page spread showing a winking nurse asking you to "keep your eye on this space in the August issue!" With that issue you learned that this was a prelude to our plea for help in obtaining information vitally required in National Office, and you were faced with filling in a good-sized questionnaire.

Many of you wondered then, I am sure, why you were being asked such questions, just as you are wondering now why you are being asked to answer them again. Certainly, we are not asking you to answer the questions twice. We are merely looking for full returns. So, in the event that you mislaid your August issue in that move to the cottage or that it hasn't yet been returned by its borrower, we are providing you with another form.

The kind of information we have asked you to provide is a basic need to any organization's plans for the future. The CNA has never had statistical data on nurses on a national basis. True, provincial associations do make certain information available to us, but not comprehensive enough for national needs in preparing studies on evaluating the nursing needs of the country; in providing information to government and other professional agencies; in interpreting nursing nationally to the press; in making predictions for the future. What it boils down to is this: *To know where we are going in the future, we must know where we are at present.*

Dr. Helen Mussallem's recent study on nursing for the Royal Commission on Health Services emphasized the absolute need for these statistics. It was then that the CNA decided to allocate sufficient funds to initiate a project for the collection and processing of such data.

Representatives of all provincial associations were asked to meet with the national association representatives to discuss the project. Though cost was certainly a concern, the major problem was to determine the best way to get the answers to our many questions. This questionnaire seemed to be the solution. It was devised with the hope that every nurse would look upon this as an opportunity to give a helping hand to her fellow nurses.

We cannot stress the importance of the need for this information strongly enough. Whatever your feelings about questionnaires might be, we ask you to take a few minutes out of your busy schedule to answer this one. Only YOU can help us with this project. We cannot do it alone.

Your National Association

CANADIAN NURSES' ASSOCIATION

74 Stanley Avenue, Ottawa 2, Ontario

SURVEY OF REGISTERED NURSES 1963

All information given will be treated as strictly confidential

NAME IN FULL: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Surname Given Name

(Legal name as appears on birth certificate or official document designating change of name. Please underline given name most commonly used)

MAIDEN NAME: ☐☐☐☐☐☐☐☐☐☐☐☐

RELIGIOUS NAME (Sisters only): ☐☐☐☐☐☐☐☐☐☐☐☐

Permanent Address: ..... Prov.: .....

Present Address: As above ..... or: ..... Prov.: .....

In sections 1 to 7 please check ☐ boxes where applicable.

1. PERSONAL DATA.

a) Marital status:
- Single ☐ 1
- Married ☐ 2
- Widowed ☐ 3
- Divorced ☐ 4
- Other ☐ 5

b) Sex:
- Female ☐ 1
- Male ☐ 2

c) Date of birth: Year ☐ 1

d) Place of birth:

If Canada, specify

Province .....

If elsewhere, specify

Country .....

2. PRE-NURSING EDUCATION.

a) What educational qualifications did you have before entering the School of Nursing? Check one
- Grade X ☐ 1
- Grade XI ☐ 2
- Grade XII ☐ 3
- Grade XIII ☐ 4
- If other, specify .....

b) Did you have a university degree before entering the School of Nursing?
- Yes ☐ 1
- No ☐ 2

c) State country in which you received the major part of your pre-nursing education

.....

3. BASIC NURSING EDUCATION.

a) Are you a graduate of:

Hospital School of Nursing ☐ 1

University School of Nursing ☐ 2

If other, specify .....

.....

b) Year course began: .....

Year course completed: .....

c) Location of School of Nursing:

City: .....

Province: .....

Country: .....

4. POST-BASIC NURSING EDUCATION.

Do you have:

a) University diploma: Yes: one year course ☐ 1

Yes: two year course ☐ 2

No ☐ 3

If yes, state major field of study:

Public Health ☐ 1

Nursing Service ☐ 2

Nursing Education ☐ 3

If other, specify .....

b) Bachelor's Degree: Yes ☐ 1

No ☐ 2

If yes, state major field of study:

Public Health ☐ 1

Nursing Service ☐ 2

Nursing Education ☐ 3

If other, specify .....

c) Master's Degree: Yes ☐ 1

No ☐ 2

If yes, state major field of study:

Public Health ☐ 1

Nursing Service ☐ 2

Nursing Education ☐ 3

If other, specify .....

d) Doctoral Degree: Yes ☐ 1

No ☐ 2

If yes, state major field of study:

Nursing Education ☐ 1

If other, specify .....

5. REGISTRATION.

a) Are you or have you ever been a registered nurse?

Yes ☐ 1

No ☐ 2

If yes, type of present registration is:

Active ☐ 1

Associate ☐ 2

Inactive ☐ 3

If other, specify .....

b) Where did you obtain your original Registration/Licence?

If Canada, specify province .....

If elsewhere, specify country .....

Year of first registration .....

c) Where are you currently registered/licensed?

Province ..... Number .....

6. EMPLOYMENT AS A NURSE IN 1962.

a) Were you employed as a nurse during the year 1962?

Yes ☐ 1

No ☐ 2

If yes, complete b) to g). If no, go to section 7.

b) State location of employment as a nurse:

Province .....

c) Did you work in any other province/state during 1962?

Yes ☐ 1

No ☐ 2

If yes, specify .....

d) Indicate the field of employment in which you worked longest in 1962:

Hospital Nursing:

Federal ☐ 1

Provincial ☐ 2

Municipal ☐ 3

Private ☐ 4

If other, specify .....

If Hospital, was it: General ☐ 5

Psychiatric ☐ 6

Tuberculosis ☐ 7

Other ☐ 8

Public Health:

- Federal ☐ 9
- Provincial ☐ 10
- Municipal ☐ 11
- Visiting Nursing ☐ 12
- Industry ☐ 13

If other, specify .....

School of Nursing:

- Hospital ☐ 14
- University ☐ 15

If other, specify .....

- Armed Services ☐ 16
- Private Nursing ☐ 17

If other, specify .....

e) Position held:

- Staff Nurse ☐ 1
- Head Nurse (Assistant) ☐ 2
- Supervisor ☐ 3
- Instructor ☐ 4
- Director of Nursing (Assistant) ☐ 5
- Consultant ☐ 6
- Hospital Administrator ☐ 7

If other, specify .....

f) Please indicate your annual salary range (before deductions):

- $10,000 and over ☐ 8
- $ 8,000 - $10,000 ☐ 7
- $ 6,000 - $ 8,000 ☐ 6
- $ 5,000 - $ 6,000 ☐ 5
- $ 4,000 - $ 5,000 ☐ 4
- $ 3,000 - $ 4,000 ☐ 3
- $ 2,000 - $ 3,000 ☐ 2
- Less than $2,000 ☐ 1

g) In the year 1962 did your practise Nursing:

- Full time on a regular basis (12 months) ☐ 1
- Part time on a regular basis (12 months) ☐ 2
  for ..... hours a week.
- Part time irregularly ☐ 3
  for ..... days in year.
- Full time periodically ☐ 4
  for ..... days in year.

h) Do you participate in any Pension or Annuity Plan?

- Yes ☐ 1
- No ☐ 2

7. FOR THOSE NOT EMPLOYED AS A NURSE IN 1962.

a) Please state main reason for not nursing:

- Retired ☐ 1
- Studying a course in nursing ☐ 2
- Married ☐ 3
- Illness ☐ 4
- Looking for employment in Nursing ☐ 5
- Employed in field other than Nursing ☐ 6

Specify .....

If other, specify .....

b) Do you intend to return to Nursing at some later date?

- Yes ☐ 1
- No ☐ 2

c) Would you return to active nursing NOW if suitable arrangements existed regarding:

- Hours of work ☐ 1
- Care for dependents ☐ 2

If other, specify: .....

.....

d) How many years is it since you were employed as a nurse?

Thank you for completing this questionnaire

SURVEY OF REGISTERED NURSES, 1962

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CONTACT LENSES

Contact lenses, worn by over 6,000,000 people in the U.S.A. and Canada, are about the same diameter as an aspirin tablet, as thick as a fine playing card, and so light that it would take approximately 500 of them to weigh a single ounce. They are worn by people in all walks of life for varied reasons:

1. As a cosmetic aid to replace conventional eye glasses;

2. following a cataract operation to provide superior vision and comfort than that afforded by the usual thick, heavy eye glasses;

3. to present an optically clear surface in cases where the cornea has become disfigured due to keratoconus or injury;

4. as a supplement to conventional eye glasses when the individual is partially blind or has sub-normal vision;

5. to change the color of the eye's iris — Hollywood has the greatest demand for this colored type of lens. — Rosenthal, J. Vision and Contact Lenses. *Vision*, 17:13, Spring, 1962.

CIGARETTE SMOKING and CARDIOVASCULAR DISEASE

The following statement was approved by the Board of Directors, Canadian Heart Foundation, Toronto, 1963 :

While coronary heart disease is common in non-smokers, cigarette smokers suffer three times the incidence and death rate from this disease, according to recent prospective studies of normal men between 40 and 49 years of age. Cigarette smoking is also known to play a significant role in the causation of obliterative arterial disease in the extremities. Other types of peripheral arterial disease which may lead to gangrene are aggravated by the smoking of cigarettes . . . It seems reasonable, in the light of present knowledge, to suggest that those men who are unusually prone to heart disease should severely limit their smoking of cigarettes.

A recent Canadian survey in an urban community showed that 40 per cent of senior high school students were smoking cigarettes and that 85 per cent of them established the habit between the ages of 12-16, inclusive. In view of this, and the fact that only a small percentage of men take up smoking after this age, it would seem most desirable to take whatever steps are necessary to discourage smoking among teenagers in Canada, in an effort to reduce the toll from heart and blood vessel disease. — *C.M.A.J.*, 88 : 1175, June 8, 1963.

FASTEN PROPERLY

Seat belts are safe when they are used properly, but improper fastening can cause injuries. A recent report in the *Journal of the American Medical Association* points up a hitherto unsuspected cause of injury from the use of a seat belt.

A woman patient brought to hospital following an auto accident, had sustained a ruptured spleen. She was short and heavy, and had fastened her lap seat belt rather high across her upper abdomen. The impact of the collision, plus the restraining action of the belt, caused sudden, severe compression of the upper abdominal viscera, with subsequent rib fractures and splenic rupture.

Proper use of the seat belt would have prevented this. The lap type belt should be placed low over the hips for normal bending of the body about the hip joints. This then permits the body to pivot forward. The belt should be tight enough so that forward hip movement is limited to not more than four inches.

Seat belts can prevent death or serious injury. Use them properly. — *Nursing Outlook*, 11:449, June, 1963.

Nursing Profiles

Beginning in 1959, nurses in each of our provinces gradually became aware of a new provincial appointee called the "editorial advisor." At first, her role may have seemed mysterious but as time passed, she became the familiar figure who asked you to fill out a biographical form; review a book; submit an address for possible publication; write an article. To your editorial staff, she is the person whom we cannot do without; her assistance is essential to the life of the *Journal*.

There have been relatively few changes in the pioneer group of advisors but, this month, we would like to introduce three replacements.

ANNA CHRISTIE

Anna Archibald Christie, who recently became educational consultant NBARN, has accepted the additional responsibility of advisor. In the short period that she has been associated with the *Journal*, Miss Christie has brought us into closer contact with the professional life of the province. We are looking forward to the privilege of working with her in the future.

A graduate of the Montreal General Hospital and of the School for Graduate Nurses, McGill University, Miss Christie has an excellent background in administration, supervision and teaching in addition to a broad knowledge of professional activities. She has a well-earned reputation as a capable and thoughtful leader within her profession.

SISTER SAINTE-BARBE

The province of Quebec, which has two advisors representing the respective language groups, has announced replacements for both of the former advisors. **Sister Sainte-Barbe**, a graduate of Laval University and of Institut Marguerite d'Youville, University of Montreal from which she secured her baccalaureate degree in nursing, has started her duties as representative of the French-speaking nurses. Already she is hard at work on her first assignments. Sister is presently on the staff of Hôtel-Dieu Hospital, Quebec City, where she is director of nursing education. Nurses in other areas of the province will remember her from her association with Hôtel-Dieu de Gaspé and Hôtel-Dieu d'Alma. In each instance she developed the program for a school of nursing.

Regretfully, we must say goodbye to **Sister Mary Assumpta**, St. Mary's Hospital, Montreal. Her contribution has been a rich one and it has been a joy to work with her. It is our pleasure to welcome as her replacement **Sister Mary Elaine**, director of nursing service, at the same hospital. Hungarian-born, Sister came to Canada as a child and obtained her education, general and professional, mainly in Montreal. A graduate of St. Mary's Hospital School of Nursing, she completed requirements for her baccalaureate

degree in nursing education at the University of Ottawa in 1961, following study at McGill and Sir George Williams Universities. Since her graduation Sister has served her hospital in a variety of capacities, beginning as a general duty nurse and succeeding to her present administrative role in 1958.

To our new advisors, we offer a warm welcome and the assurance of our grateful appreciation of your services.

SISTER MARY ELAINE

The NBARN recently announced the appointment of the new executive secretary, **Gwendolyn (Wilson) Hermann**, to fill the position left vacant by the sudden death of Muriel Archibald. Born in New Brunswick, Mrs Hermann is a graduate of Royal Victoria Hospital, Montreal and of McGill University where she secured her certificate in public health nursing and, more recently, her bachelor's degree in nursing, specializing in nursing education. After several years as a staff nurse in hospitals and as a member of the V.O.N., Mrs. Hermann joined the staff of the Monction Hospital School of Nursing as an instructor. In 1961 she became assistant director of nursing education, leaving this position to assume her present duties.

Ina McEwen, a public health nurse in Sarnia, Ont., is retiring after 37 years of service in this field. Born in Michigan, Miss McEwen came to Ontario as a small child and received her early education in that province. Later, she returned to Michigan to Port Huron General Hospital for her professional preparation. Postgraduate work

GWENDOLYN HERMANN

in public health was undertaken at Ann Arbor, Michigan, St. Catherines and Toronto, Ont. She joined the Sarnia Board of Education in 1925, remaining on staff when this service was absorbed by the Sarnia Board of Health. In 1946 Miss McEwen became nursing supervisor of the newly formed Lambton Health Unit. She has always taken an extremely active interest in social welfare work and community activities. She has served on the board of directors of such organizations as the Canadian National Institute for the Blind, the local Red Cross Society, and Goodwill Industries. Recently Miss McEwen became a counsellor for the Sarnia unit of the Mental Health Association. In addition, she is a member of the Business and Professional Women's Club and the Zonta Club.

INA MCEWEN

Winnifred M. Cooke has retired from her position as director of nursing and principal of the school of nursing, General and Marine Hospital, Owen Sound, Ont. A graduate of Montreal General Hospital and of the McGill University School for Graduate Nurses, her nursing career has centred around teaching and administration in such centres as Montreal, Victoria, Ottawa and Owen Sound. For a five-year period, she was on the staff of National Office in the capacity of assistant secretary.

An active participant in the work of her provincial professional association, Miss Cooke has also served as president of the Business and Professional Women's Club in Owen Sound. In addition she was a member of the Board of Directors of the local V.O.N. branch. Her future plans include settling into a new home in the Laurentian Mountains which she will share with her two sisters.

Norah E. Armstrong, graduate of the Vancouver General Hospital and of the University of British Columbia where she obtained the degree B.A.Sc., has retired after 33 years of service with the North Shore Health Unit, Vancouver. This unit was first established in 1930 with the assistance of provincial and Rockefeller Foundation grants. At that time it was known as the North Vancouver Health Unit. Its first director was Dr. G. F. Amyot, who retired from the post of Deputy Minister of Health in 1961, while the nursing staff consisted of Miss Armstrong and one other nurse. Together they looked after the needs of the 14,527 people within the area. This same unit today has a staff consisting of the director, 24 public health nurses, 3 public health inspectors, a psychologist, five clerical workers and six part-time assistant health officers, to serve a population of 92,476. Throughout the years, Miss Armstrong provided loyal support to the directors of the unit, carried a heavy load of administrative responsibility, and exerted considerable influence on the development of services provided.

The Spirit of Nursing

This fine piece of sculpture adorns the front lawn of the new Nanaimo Regional Hospital, Nanaimo, B.C. It was presented to the hospital board by Mrs. Anne Quayle, president of the local chapter, Registered Nurses Association of British Columbia, on behalf of the Nanaimo chapter members.

As the lighted candle is a symbol of Nursing, so this beautiful piece of work depicts, in marble, the flame of the candle, the purity of purpose and the spirit of nursing as typified by Florence Nightingale in bringing light and encouragement, hope and a prayer to those in distress.

The sculptor is Gerald Carter, an instructor at the Vancouver Art School. Mr. Carter received his inspiration from the white candle used in traditional capping ceremonies. The sculpture stands six feet high on a concrete base and is made of white marble chips.

In Memoriam

The alumnae association of the Public General Hospital, Chatham, Ont. pays tribute to the memory of the following graduates: **Mable Arville (Curtis) Aitken** '12 and **Inez M. (Roach) White** '19.

* * *

Elaine Loretta (McLellan) Bledsoe (St. Joseph's Hospital, Phoenix, Arizona '24) died in California on May 22, 1963. She was a former resident of Vancouver, B.C.

* * *

The alumnae association of the Ottawa Civic Hospital records the loss, through death, of the following graduate: **Mabel Ethelwin Booth**, a nursing sister in World War II.

* * *

Evelyn Burdon (Strathroy General Hospital, Ont. '30) died recently. She had engaged in institutional nursing.

* * *

The alumnae association of St. Joseph's Hospital School of Nursing, Victoria, pays tribute to the memory of: **Kathleen Clark** '33; **Beryl (Gamble) Milner** '18; **Bertha (Hare) Reid** '26.

* * *

Marie Rose Clark, a former resident of Nova Scotia, died in Winnipeg on March 7, 1963. She had been employed as a C.P.R. nurse for a total of 48 years.

* * *

Ethel Cook (Lynhurst Hospital, Toronto '20) died early this year. She had engaged in office nursing.

* * *

Nita (Jackman) Curror (Victoria Union Hospital, Prince Albert, Sask. '24) died in May 1963 after a long illness.

* * *

Amy Irene (Rollins) D'Andrea (Saint John General Hospital, N.B. '38) died on June 20, 1963. She had engaged in district nursing in St. Andrews, N.B.

* * *

Hilda Maud Dixon (Galt Hospital, Lethbridge, Alta., '17) died in Winnipeg at the age of 82 years.

* * *

Ivy Lucille (de Leon) Fobert (St. Michael's Hospital, Toronto '27) died on May 2, 1963. She engaged in private nursing during her professional career.

John A. Fougere (Nova Scotia Hospital, Dartmouth '27) died suddenly during April, 1963. He had served with the R.C.A. Dental Corps during World War II and for the past 15 years occupied a supervisory position on the staff of the Nova Scotia Hospital.

* * *

Annabelle Margaret (MacMillan) Foley (Kingston General Hospital '41) died in Winnipeg on May 25, 1963.

(Columbian Photo, New Westminster)

SARAH GARVIE

Sarah (Pattinson) Garvie (Royal Columbian Hospital, New Westminster, B.C. '06) died on April 5, 1963. Mrs. Garvie, a highly respected and much loved member of the profession, had been employed by the New Westminster Private Duty Directory prior to her death. She was 77 years of age.

* * *

Carolyn Elizabeth (Rickard) Gustin (Binghamton State Hospital, Binghamton, N.Y. '35) died in Toronto early this year. She had been engaged in institutional nursing.

* * *

The alumnae association of St. Boniface General Hospital, Man., records the loss of the following graduates: **Jocelyn B. (Pilling) Horvath** '56 and **Lillian Lavack** '57. Mrs. Horvath and Miss Lavack, a head nurse on the staff of her hospital, died as the result of an automobile crash.

* * *

Jeannette Y. Jacques (Hôtel-Dieu Hospital, Sherbrooke '53) died in Montreal on June 23, 1963.

* * *

Florence Kirkwood, a former resident of Prince Edward Island and a graduate of a Charlottetown hospital, died in Fort Garry, Manitoba on March 8, 1963.

RED CROSS CENTENARY

This year the world is commemorating the 100th anniversary of the birth of the International Red Cross. Observances have been planned throughout 1963 by the national Red Cross, Red Crescent and Red Lion and Sun Societies of more than 90 nations. The highlight of the commemorative observances is taking place during August and September in Geneva, the birthplace of the Red Cross. A series of meetings and conferences on various aspects of Red Cross work will culminate with the Centenary Congress of the International Red Cross.

Among the many sessions in Switzerland is an international conference on nursing, which HELEN G. MCARTHUR, national director of nursing services of the Canadian Red Cross Society, will attend as chairman of the nursing advisory committee of the League of Red Cross Societies. HELEN K. MUSSALLEM, executive director of the Canadian Nurses' Association will also be present as a newly-apointed member of the nursing services committee of the Canadian Red Cross Society.

When Henri Dunant proposed the Red Cross movement in 1863, he envisioned volunteer societies primarily concerned with the welfare of victims of war. This was based on his personal experiences at Solferino in 1859. At this time, he inspired villagers to give treatment and care to the wounded of both armies.

In the past 100 years, there have been many development in Red Cross nursing activities. Today, Red Cross nurses are active in many varied services. They participate in disaster relief, public health work, educational, medical and hospital activities. In Canada, they are employed in the blood transfusion service, outpost hospitals and nursing stations. Some are active in Junior Red Cross work. Registered nurses serve as volunteers at baby clinics, blood donor clinics, as instructors of Red Cross home nursing classes and, in many communities, handle the administration of the community sick room loan service. Others serve as voluntary officers at national, divisional and branch levels.

There are 28 Red Cross, Red Crescent and Red Lion and Sun Societies operating basic schools of nursing; three have postgraduate schools of nursing; 35 conduct specialized courses for nurses; 40 train nurses' aides; a large number organize home nursing courses; 28 conduct hospital services of a general or specialized nature; 60 recruit and train Red Cross nurses to serve in public health institutions, health centres, school health pro-

A Red Cross team arrives

A lesson in techniques

grams, industrial health services and collective farms; 35 include nursing services as an integral part of disaster relief programs.

Almost all Red Cross Societies recruit nursing personnel for the military medical services of their nation when there is a need.

Nursing and the Canadian Red Cross have been associated since 1919, prior to the time that its Act of Incorporation was amended to permit the latter to carry out peacetime work. The Canadian National Association of Trained Nurses invited the Society to cooperate in a sweeping program to improve and expand the country's nursing services. A final result was the inauguration of Canada's first university course in public health nursing at Dalhousie University early in 1920. Four other universities opened courses in the fall term of the same year. The Canadian Red Cross Society has been credited with influencing the formation of these courses and of financing them, either wholly or in part, during the demonstration period.

Another nursing project of the Canadian Red Cross was prompted by the dissatisfaction of the CNA with prevailing methods of nursing education. The Metropolitan Demonstration School of Nursing, at Windsor, Ontario, enrolled its first class in 1948 with the support of grants of up to $40,000 a year from the Society. Its purpose: To prove that nurses could be prepared in less than the usual time. The success of this venture was vindicated in recent years with the opening of the Nightingale School of Nursing in Toronto and by the interest shown by other cities and countries.

Since 1950, bursaries have been awarded to 18 nurses on Red Cross staff for diploma courses in public health nursing, administration, and obstetrical nursing. Since 1959, fellowships have been awarded to three outstanding Canadian nurses to assist them in obtaining a doctorate and a similar number have been granted to nurses from Greece, Turkey and Panama.

Another phase of nursing cooperation, in recent years, has been the recruitment of Canadian nurses to serve on Canadian Red Cross assignments in other lands. Under this plan, Canadian nurses served in Austria and The Netherlands at the time of the Hungarian uprising; in Agadir after the disastrous earthquake, and in the Congo. In 1962, four nurses assisted in the repatriation of Algerian refugees from Tunisia and Morocco.

Executives' Seminar

LOUISE PARK

Thirty-five nurses from across Canada were privileged to attend a two-week seminar for senior nursing executives which was planned and conducted under the excellent leadership of Dr. Amy Griffin, associate professor in nursing administration, School of Nursing, U.W.O. and held at the University of Western Ontario, London, June 17-29, 1963. The program was greatly enhanced by the able participation of Dean R. Catherine Aikin; members of the school of nursing faculty; Dr. Edith McDowell, former dean of the School of Nursing; Mr. Craig Lundberg, School of Business Administration, U.W.O.; Miss Alma Reid, McMaster University; Miss Margaret Campbell, University of Alberta; Miss Margaret Street, University of British Columbia. Much of the dynamic impact of the seminar came not only from the expert knowledge and rich experience of these individuals in their own particular fields, but also from the close-knit, harmonious functioning of this "all Canadian" team, and its keen interest in the promotion of a learning experience which would be meaningful and worthwhile to all.

Three basic beliefs guided the program planning:

That effective administration can be learned;

that administrative behavior can be improved through a deepened understanding of the administrative process and the skills which implement it;

that the morale and efficiency of an entire organization reflect the morale and efficiency at the top.

The program was designed to assist senior nursing executives to improve their own performance and to increase general satisfaction. It's ultimate aim was the achievement of improved nursing service to the public at large in hospital, industry, or the community.

Several methods of study were employed: lectures, discussion periods, case study, workshop sessions and individual study sessions. Each participant received a composite bibliography and selected resource material. In addition, several publishing companies provided a display of their latest material of pertinent interest.

During the first morning, attention was directed to formal and informal organization and an understanding of the individual's role, needs, satisfactions and conflicts as they relate to the attainment of an organization's objectives. Understanding of these concepts was strengthened by study of several theories of administration from related professional disciplines such as business and education. Their significance and implications were more fully realized through individual and group thinking focussed on a related study.

Consideration of the administrative process and the administrator's functions followed, with special emphasis on the decision-making process and the responsibilities of the administrator in relation to this. Subsequently participants formed three "pure" groups — public health nursing, nursing service and nursing education — and concentrated on situations in their specific fields involving crucial decisions an administrator must make; how these are reached; their apparent implications and consequences.

Recognizing that patients form an impression of the philosophy of the organization from the personnel with whom they come in contact, participants grappled with the problem of determining the philosophy of a hypothetical organization as it might be judged from sample behavior exhibited by the director of nursing, a supervisor or a head nurse. A research project conducted by Hagen and Wolff* provided a guide.

In small groups, participants considered several of the skills required by an effective administrator, for example those involved in planning and organizing; problem solving; initiation of innovations; the placement and use of power and authority. An attempt was made to decide what functions require a high degree of conceptual, human or technical skills, or various combinations of these; to recall specific instances in which a high or an unacceptable level of these had been observed; to decide where greatest strengths and weaknesses lay.

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*Hagen, E. and L. Wolff. *Nursing Leadership Behaviour in General Hospitals*, New York: Teachers College, Columbia University.

Following a paper by Dean Aikin on the principles underlying the formulation of effective personnel policies, the entire group became involved in a lively discussion on the problems related not only to the formulation but also the implementation of them. Through consideration of a relevant case study the group arrived at some solutions to these problems.

Professor Lundberg concentrated on the dynamics of human behavior. He directed thinking to man — what he is; how he communicates; communication roles; communication breakdown. He differentiated between the ideal, real and adequate self-concept and considered with us the concepts of man's needs and abilities, and the importance of these in terms of motivation and change in behavior. He described the development of maturity and indicated guideposts to a healthy personality. He discussed patterns and consequences of behavior; judgments made on the basis of behavior; how behavior is exhibited; interpersonal behavior needs and the ways in which we react to others. Considerable time was spent on leadership: The difference between *leadership* and *headship*; leadership functions and traits; dimensions of behavior exhibited by leaders; consideration of whether leadership is, in essence, a man or a function.

The first two days of the second week were planned as a workshop. Focal points of discussion were: Current problems and progress in each specific field of nursing; present trends; what personnel seek in the way of cooperation from those in other areas in order to promote common objectives and to assist in achieving objectives specific to each field of nursing.

Public Health Nursing

The summation of progress and trends in relation to this field concerned the organization, its administration, its personnel, and the community. It was felt that there had been an improvement in public health nursing service.

1. *Assessment of needs:* The public health department is studying the community in an effort to make a better assessment of its needs. These may vary greatly from one geographical area to another and are influenced by such factors as social and economic resources.
2. *Examination of present programs:* Existing programs are receiving critical evaluation in relation to changing needs.
3. *Improved staff development:* Through orientation, o n - g o i n g educational programs, supervision and evaluation, the public health nurse is receiving help in the development of new skills and substitution of strengths for weaknesses.
4. *Health service to the family:* This has been retained and strengthened, often in spite of other pressures in the program. Furthermore, it has been enhanced by new knowledge, by giving more attention to the psychological factors inherent in such service, and through better use of community resources. This change involves the whole cycle of service from prenatal care up to and including, our senior citizens.
5. *School programs:* These are still demanding of time and service. Varying degrees of success are being achieved in many areas by placing emphasis where it is most needed. Many old routines have been discontinued. Current emphasis is on counselling, nurse-teacher conferences and the use of the public health nurse as a resource person.
6. *Home Care Program:* Not only is there a trend toward increased home care, but also recognition of responsibility for its establishment entailing consideration of such factors as: tax dollars; availability of hospital beds; job satisfaction for personnel and better utilization of them; recognition of the worth of the individual in sickness and in health.
7. *Communications:* Although far from i d e a l, communications to the general public and to specific groups have improved. It is hoped that more use will be made of mass media such as radio, television, the press.
8. *Expansion of health services:* In order to serve an increased population, new health units are being formed, and existing ones are being extended.
9. *Inter-agency relations:* Public relations between hospital and p u b l i c health agencies have improved, promoting continuity of nursing care. Hospital visiting by the public health nurse, visits by hospital personnel to the health agency, and the establishment of hospital health services have contributed to this improvement.
10. *Graduate studies:* Public health nurses are showing decided interest in study leading to baccalaureate and master's degrees. There is increased availability of financial aid.

Participants identified the following problem areas in which public health nurses cur-

rently look for further improvement:

1. Turnover of staff;
2. lack of communication with other health and social agencies;
3. provision of an improved period of observation for students in hospital schools of nursing;
4. lack of general knowledge of public health services by the public and the need for more interpretation to Boards of Health;
5. unrealistic programs in terms of available staff;
6. the use of auxiliary personnel;
7. clarification of job description for Medical Officers of Health; improvement of preparation and better selection of personnel; salary commensurate with the nature and extent of responsibilities carried.

Many solutions to these problems were suggested. Most important was the fact that problems were faced, put into words and looked at critically from an administrator's standpoint. Of particular value was the unique opportunity provided by the seminar for total group discussion by executives from all fields of nursing. There was free exchange of ideas and sharing of experiences. Some of the most important observations were:

1. The discrepancies between theory as presented in university and practice as carried out in the field.
2. The need for development of tools of evaluation and an appreciation of evaluation as an important technique in the improvement of services and the promotion of professional growth.
3. The need for improved preparation of administrators at all levels with greater emphasis on the theory of skills of administration, interpersonal relationships and the dynamics of human interaction.

One day of the seminar was devoted entirely to a consideration of evaluation. Dr. McDowell discussed the basic concepts of evaluation and the development of criteria for the evaluation of top-level administrators in nursing. Concepts came to life in a follow-through with a case study approach. Three mixed groups struggled to design tools for evaluation; carried out a critical assessment of them and considered a total program of evaluation including purpose, methodology, personnel, and use. A program of evaluation has meaning for individuals only to the degree to which they become involved in its construction and implementation. For example, if as administrators we encourage staff to cooperate in developing an evaluation form, they learn what is expected.

On the last day participants looked briefly to the future. Of chief concern was the method of selection of people with administrative potential and the promotion of their professional and personal growth. Stress was laid on the responsibility of the individual for the realization of her professional potential but with parallel assumption of responsibility by the employing agency, the professional organization and the universities to contribute to this.

The lively, good-natured "debate in the house," which constituted the final session bore witness to the interest sustained throughout the entire seminar, and to the freedom and responsibility felt and exercised by the participants to hold and defend their own opinions. This debate, which was designed to get at the heart of our concern for modern nursing was centred around a thoughtful statement by Luther Gulich and Lyndall Urick in 1937 in their publication "Papers on the Science of Administration."**

> Human beings are compounded of cognition and emotion and do not function well when treated as though they were cogs in motion. Their capacity for great and productive labor, creative cooperative work, and loyal self-sacrifice knows no limits provided the whole man — body, mind and spirit — is thrown into the program.

The debate was triggered by the challenge:

> In 1963, I contend that now, more than ever, nurses do not throw themselves, body, mind and spirit, into the program of any agency in which they are employed, and that this is the most important single contributing factor in the present unsatisfactory standard of nursing service which we render.

Looking back on the total experience, three aspects of the seminar stand out particularly clearly: The value of sharing in the experiences of others; the fellowship enjoyed in work and leisure; the repeated focus on ourselves as administrators. Some found this realistic self-reflection more than a little disturbing, but seldom have we felt so definitely the challenge to self-improvement and the reassurance of specific guides.

** *Papers on Science of Administration.* New York: Institute of Public Administration, 1937.

About Books

Strecker's Fundamentals of Psychiatry by M. M. Pearson, M.D. 274 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal 6. Ed. 6, 1963.

This book is based on the author's philosophy that medical students and general practitioners should have a good understanding of the main principles of psychiatry. He believes that it is essential for all physicians — whether in general practice or in a specialty — to be able to give supportive psychotherapy to patients who require it, since the number of psychiatrists is inadequate to meet present day needs in this area.

The objective of this book is to provide easily understandable information regarding the importance and aims of psychiatry; etiology, classification and diagnosis of mental illness; and methods of treatment.

Although the statistics and committee reports included pertain to the U.S.A., they are similar to those in Canada. The 1961 report of the Joint Commission on Mental Illness and Health, that analyzed the *needs* and *resources* of the mentally ill in the U.S.A., closely resembles that of the recent "Mental Health Services for Canada" committee report. One point stressed in both is that the mentally ill person should not be isolated from the community in a large, impersonal institution several miles from town. He should be provided with services in a psychiatric unit within a general hospital, or in a smaller psychiatric institution.

The chapter concerning classification of mental diseases is well presented. The classification given is that adopted by the American Psychiatric Association in 1952. It is interesting to note that psychosomatic illnesses are now called "psychophysiologic autonomic and visceral disorders;" the term "mental deficiency" refers only to those persons who have had an intelligence defect since birth. The defect is then classified as *mild, moderate* or *severe* — not moron, imbecile or idiot.

A comprehensive description of the nurse's role in relation to psychiatric patients comprises the content in chapter eight. I would disagree, however, with the author's contention that there are two kinds of good nurses — the first group including those who provide competent physical care, and the second group including those who, in addition to giving skilful physical care, have the capacity to understand the patient as a person. It would seem to me that the former does not belong in the category of "good nurses."

Advances in psychopharmacotherapy have been added to this edition, as well as an up-to-date review of the drastic therapies (insulin shock, electroshock and prefrontal leukotomy) I was surprised that the author did not include any information concerning the use of lysergic acid diethylamide as a possible therapeutic agent in alcoholism and other addictions.

This text would be an excellent reference book for a school of nursing library. Certain chapters, particularly the one concerning the nurse, would provide interesting and valuable information to the student or graduate nurse.

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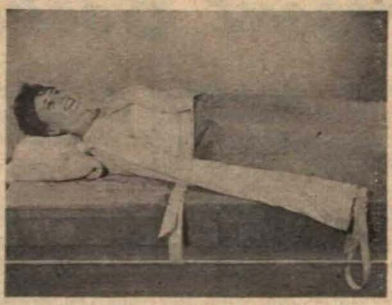

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Scientific Principles in Nursing by M. Esther McClain and Shirley Hawke Gragg. 448 pages. U.S.: The C. V. Mosby Company. Canada: McAinsh & Co. Ltd., 1251 Yonge St., Toronto 7, Ed. 4. 1962. *Reviewed by Mrs. Beverley Faulks. School of Nursing, St. Joseph's Hospital, Victoria, B.C.*

This edition very excellently accomplishes its purpose in showing how basic scientific principles may be used in nursing practice. A very comprehensive presentation of fundamental nursing theory, essential to beginning students, is provided. Information is clearly and logically presented and is supplemented with good illustrations as well as useful reference tables for diagnostic tests, common nursing abbreviations and equivalent measures. Information is up-to-date and good references are provided. The inclusion of community, as well as hospital aspects of care provides a means for the reader to gain a comprehensive view of the patient.

The author very capably combines the principle-centred, procedure-centred, and patient-centred approach in presenting the subject matter. Pertinent scientific principles are clearly stated and simply explained. The reader is led logically and easily to see their application in nursing procedures and in the development of good nurse-patient relationships. Each chapter also includes significant aspects of learning for the patient and presents a "life-situation" and stimulating questions for discussion. These would be extremely useful in teaching. At the close of each chapter is a student check-list that should serve very well to assist the student in analyzing problems and in formulating a logical approach to their solution.

I consider this text to be excellent for use by an instructor in the subject, and as a textbook for the personal use of beginning students. Its strong point, I feel, is its clear systematic presentation of scientific principles and their application to both nursing procedures and to the development of good nurse-patient relationships. In presenting the subject matter, the author has shown the reader a consistent and logical way of thinking through nursing problems, and has provided stimulation for the use of this method in other situations.

A History of Nursing by Isabel M. Stewart and Anne L. Austin. 516 pages. G. P. Putnam's Sons, New York. Ed. 5. 1962. This text is a revised edition of "A Short History of Nursing," by Lavinia L. Dock, originally published in 1920. It is written primarily for student nurses with the hope of providing a "broader view of nursing history" than previously presented. The authors believe that nurses today need to have an understanding of nursing in other countries — its development and progress — as well as an awareness of the national and international organizations and agencies that influence nursing. The objective of this text, therefore, is to present this "world view of the nursing situation."

The book is divided into two sections: the

first presents a history of nursing from ancient times to the Nightingale era; the second part describes the progress of modern nursing in various countries, from the 1860's to the present. This division seems logical; a clear picture of the *general* background of nursing is provided, before delving into the specific. The first part is intended primarily for beginning nursing students.

The introduction to nursing origins and history, as presented in chapter I, is an interesting approach. A first-year student of nursing should benefit from this short, but comprehensive over-view.

The chapter "Influence of the Early Church" is, perhaps, too condensed. More detail regarding certain personalities, e.g. Fabiola, would add interest to this section.

It is interesting to note, as discussed in Part Two under the chapter heading "Great Britain and Ireland," that since the inception of the National Health Service:

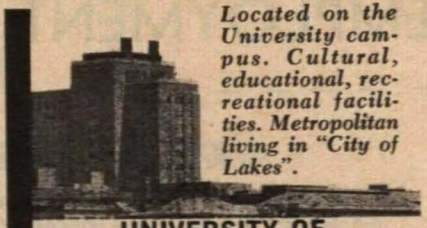
> The General Nursing Councils . . . now have less responsibility for inspecting and approving schools, determining standards of practice, preparing the official syllabus, conducting examinations, and the like, but are expected to advise the national ministries now concerned with these problems . . .

This statement allows the reader to visualize the effect that socialized medicine would have on the nursing profession if it should be accepted in Canada.

The chapter concerning nursing in Canada is well written; it will be of interest to graduate as well as to student nurses. No mention is made, however, of how the nurses of this country achieved professional status and registration.

Occupational Therapy by Helen S. Willard, B.A., O.T.R., and Clare S. Spackman, B.S., M.S. (Ed.), O.T.R. 473 pages. J. B. Lippincott Co., 4865 Western Ave., Montreal. Ed. 3. 1963.

This text is a revised edition of *Principles of Occupational Therapy*. New material concerning major developments in theory, research and clinical practice has been added to this edition, and sections concerning history, educational aims, etc. of the profession have been deleted. Arthritis has been included under the treatment of physical disabilities, and greater stress has been placed on the care of cerebral vascular accidents, paraplegias and hemiplegias. Eight new authors have added contributions to this edition.



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Registered Nurses (7) and Certified Nursing Aides (5) for new 30-bed hospital at present under construction, opening in Aug. Good personnel policies, maintenance in new nurses' home for $35. Apply: Matron-Administrator, General Hospital, Bashaw, Alberta. 1-4-1

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General Duty Nurses for well-equipped 76-bed hospital in active town of 3,000. Salary $300-$350 for Alberta registered; $290-$340 for non Alberta registered. New separate residence, excellent personnel policies & working conditions. Apply to: Director of Nursing, Brooks General Hospital, Brooks, Alberta. 1-13-1

General Duty Nurses. Starting salary: $300 per mo., 40 hr. work wk. Room, board & laundry available, if desired, at nominal rates. Civil Service holiday, sick leave & pension benefits. Apply to: Baker Memorial Sanatarium, Dept. of Public Health, Calgary, Alberta. 1-14-3

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Head Nurse, male or female, for active Operating Room Unit. Postgraduate training required. Good personnel policies; residence accommodation available (female). Apply to: Director of Nursing, Trail-Tadanac Hospital, Trail, British Columbia. 2-72-1

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General Duty Nurses for 40-bed hospital. Salary for B.C. Registered Nurses $320-$387 and $305 for non B.C. Registered. Nurses' residence available. Apply: Director of Nursing, Nicola Valley General Hospital, Merritt, British Columbia. 2-41-1

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Registered Nurses and Certified Nursing Assistants for 160-bed accredited hospital. Starting salary $340 and $235 respectively with regular annual increments for both. Excellent personnel policies. Residence accommodation available. Assistance with transportation can be arranged. Apply to: Director of Nursing, Kirkland & District Hospital, Kirkland Lake, Ontario. 7-67-1

Registered Nurses and Certified Nursing Assistants for immediate and future vacancies in this 42-bed hospital. Starting salaries $335 and $225, respectively. Accommodation in new residence available. Usual fringe benefits. For full information, apply to: Director of Nursing, New Liskeard and District Hospital, New Liskeard, Ontario. 7-83-1

Registered Nurses and Certified Nursing Assistants for 26-bed hospital. R.N. minimum salary $340, maximum $380, 28-day vacation after 1-yr. C.N.A. minimum salary $244, maximum $275, good personnel policies, 2-wk. vacation after 1-yr., 3-wk. after 2 yrs. Credit for past experience, $5.00 increment every 6 mo., 40-hr. wk. 8 statutory holidays. Room & board $45 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario. 7-87-1

Registered Nurses and Registered Nursing Assistants for 60-bed hospital. Excellent personnel policies includes 5-day wk., 8 statutory holidays and pension plan. The town has a fine quarry for your swimming pleasure and Stratford's Shakespearian Festival is only a few miles away. Apply: Superintendent, Memorial Hospital, St. Marys, Ontario. 7-112-1

Registered Nurses for General Duty in well-equipped 28-bed hospital, located in growing gold mining and tourist area, north of Kenora, Ontario. Modern residence with individual rooms; room, board and uniform laundry only $45. 40-hr. wk., no split shift, cumulative sick time, 8 statutory holidays and 28 day paid vacation after one year. Salary range $350 - $375. Apply to: Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario. 7-29-1

Registered Nurses for General Duty in all departments including premature and new-born nursery, Isolation Emergency and Recovery Room. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10

Registered Nurses for General Duty & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 80,000 people. **Salary: $325 per mo.** with annual merit increments, plus **annual bonus plan,** 40-hr. wk. Recognition for **experience.** Good personnel policies. Assistance with transportation can be arranged. Apply: Director of Nursing, Memorial Hospital, Sudbury, Ontario. 7-127-4

Registered or Graduate Nurses for modern 100-bed hospital located in summer resort district, 40-mi. from Ottawa. Apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario 7-120-2

GENERAL DUTY REGISTERED NURSES for 200-bed hospital situated in a beautiful residential town on the shores of Lake Temiskaming. Starting salary $340, good personnel policies including 40-hr. wk., O.H.A. pension plan, etc. Accommodation available in residence if desired. For particulars apply to: Director of Nursing, Misericordia Hospital, Haileybury, Ontario. 7-54-1

General Duty Registered Nurses (Applications are being considered at The Parry Sound General Hospital), generous personnel policies and promotion possibilities available. Apply to: The Director of Nurses, General Hospital, Parry Sound, Ontario. 7-97-1

General Duty Nurses for an accredited 66-bed hospital. Starting salary: $325. Excellent personnel policies, pension plan, residence accommodation only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario. 7-45-1

General Duty Nurses for 74-bed hospital close to Toronto, Hamilton and other large centres. Located in pleasant rural town of 11,000 with daily train and bus service. Salary at city levels with good personnel policies and benefits. All facilities are just 2 years old. Apply to: Director of Nursing, Georgetown and District Memorial Hospital, Georgetown, Ontario. 7-49-1

General Duty Nurses for new 70-bed hospital in Muskoka District. Starting salary $305/m., good personnel policies. Apply: Director of Nursing, Huntsville District Memorial Hospital, Huntsville, Ontario. 7-59-1

General Duty Nurses for modern 100-bed hospital. Registered Nurses $315-$345 per mo., Graduates $250-$295; 40-hr. wk., benefits include accident, sickness and life insurance, hospital and medical insurance plans, & OHA Pension Plan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario. 7-69-1

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Required for this accredited 250-bed hospital in the Seaway Valley. University preparation required. Salary commensurate with qualifications and experience. Apply to Administrator, Cornwall General Hospital, Cornwall, Ontario.

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General Duty Nurses Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach and great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General and Marine Hospital, Collingwood, Ontario. 7-31-1

General Duty Nurses & Certified Nursing Assistants for new 50-bed hospital with modern equipment. 40-hr. wk., 8 statutory holidays, excellent personnel policies & opportunity for advancement. Tourist town on Georgian Bay. Good bus connections to Toronto. Apply to: Director of Nurses, General Hospital, Meaford, Ontario. 7-79-1

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose and throat and orthopedic surgery. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10A

Public Health Nurses (Qualified) for generalized Public Health program. Salary: $4,000 to $5,000 with allowance for experience. Car allowance, P.S.I., Hospitalization and Pension Plan available. Accumulative sick time. Apply to: Dr. M. G. Powell, Director, Peel County Health Unit, 44 Nelson St. W., Brampton, Ontario. 7-16-2

Public Health Nurses (Qualified) for generalized program by Stormont, Dundas and Glengarry Health Unit, located in the Seaway Valley area. Minimum salary $3,700 with a commensurate increase upon satisfactory completion of 12 mo. service. Allowance for experience. 5-day wk. P.S.I. Employer-shared group insurance, pension plan and Ontario hospital insurance. 3-wk. vacation. Cumulative sick leave credits, 1/2 paid as bonus upon separation after 3-yr. service Generous car allowance. Apply in writing giving full particulars to: Miss Glenna French, Supervisor of Nursing, Box 1058, Cornwall, Ontario. 7-34-5

Public Health Nurses (qualified) Salary $3,800 - $4,800. Car allowance, employer shared pension plan and other benefits. Apply to: Mr. Allan F. Stewart, Secretary-Treasurer, Wentworth County Health Unit, Court House, Hamilton, Ontario. 7-55-14

Public Health Nurse for the City of London. Must have public health nursing degree. Full civic benefits. Salary dependent on experience and qualifications with range from $4,175 - $5,185 yearly. Address all correspondence to: W. J. Anthony, Personnel Director, City Hall, London, Ontario. 7-73-12

Public Health Nurse, Lennox and Addington County Health Unit. Salary range, pension plan and other personnel policies will be supplied on request. Applicant need not own a car. For further details apply: M. S. Wilson, Secretary-Treasurer, Box 130, Napanee, Ontario. 7-133-1

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Public Health Nurses (qualified) for generalized nursing service. Salary range: $3,800-$4,750 based on experience. Apply to: Dr. J. M. McGarry, M.O.H. St-Catharines-Lincoln Health Unit, St. Catharines, Ontario. 7-111-4

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Registered Nurses for General Floor Duty and Supervisory positions, also Nursing Assistants, for 110-bed hospital for tuberculosis and other chest diseases. Situated in the heart of the Laurentian Mountains, 55-mi. north of Montreal. Good recreational facilities. Salary in accordance with the Association of Nurses of the Province of Quebec recommendations, with full maintenance, including private room in modern nurses' residence. 40-hr. wk., 8 statutory holidays and 4-wk. annual vacation. Apply: P.O. Box 1000, Ste Agathe des Monts, Quebec. 9-57-1

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Registered Nurses (2) for 10-bed hospital. SRNA recommendations accepted. Please state qualifications. Accommodations and board $34.50/m. Apply in writing to: R. Lyle Craven, Sec.-Manager, Union Hospital, Beechy, Saskatchewan. Duties to commence as soon as arrangements are made. 10-5-1

Registered Nurses, Male or Female, for 500-bed modern General Hospital. General Duty positions available on general medical and surgical wards, pediatrics and maternity. Personnel policies comparable to Saskatchewan Registered Nurses' Association recommendations. Recognition given for experience. Must be eligible for Saskatchewan registration. For further information write: Director of Nursing Service, Regina Grey Nuns' Hospital, Regina, Saskatchewan. 10-109-7

Registered Nurses (2) for the Riverside Memorial Union Hospital, Turtleford, Saskatchewan. Salary range $310-$385. Excellent personnel policies. Room and board available. Nurses' residence. Modern hospital with addition planned in the near future with two Doctors in attendance, situated near modern village in good community, surrounded by several summer resorts. Daily bus service to Saskatoon. Apply giving date of availability and particulars to: Sec.-Manager, Riverside Memorial Union Hospital, Turtleford, Saskatchewan. 10-125-1

Registered or Graduate General Duty Nurses for 25-bed hospital. Salary as per SRNA policy: $310 to $385, room and board: $1.15 per day. 5 day, 40-hr. wk. No split shifts. Evening and night shift with extra pay if out of ordinary rotation. 9 statutory holidays, 3 wk. vacation. Free laundry, modern nurses' residence near hospital with TV — 2 channels. Phone: 2-2668 days, 2-2551 evenings or write: Mrs. Janie Sutherland, Superintendent of Nurses, Union Hospital, Eston, Saskatchewan. 10-33-1

U S A

Staff Nurses for 24-bed accredited hospital. Starting salary: $410 with $20 differential for evenings and nights. Vacation and sick leave. 9 paid holidays. Blue Cross Plan. Located in Southeastern Alaska. Apply: Dorothy Thomsen, Administrator, Sitka Community Hospital, Box 500, Sitka, Alaska. 15-2-5

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Registered Nurses. Career satisfaction, interest and professional growth unlimited in modern, JCAH accredited 254-bed hospital. Located in one of California's finest areas, recreational, educational and cultural advantages are yours as well as wonderful year-round climate. If this combination is what you're looking for, contact us now! Staff Nurse entrance salary $370 with automatic increases to $435 per mo., supervisory positions at increased rate. Special area and liberal shift differentials paid. Excellent benefits including Blue Cross hospitalization and surgical coverage and liberal personnel policies. Professional staff appointments available in all clinical areas to those eligible for California licensure. Write today: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California. 15-5-12

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Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $375 per mo. plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California. 15-5-39

Registered Nurses, Staff Nurses for permanent positions, various departments, days, eves., nights. Excellent starting salary, increments, benefits and working conditions in one of the largest and finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California. 15-5-3G

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Registered Nurses for 233-bed modern hospital. Positions available — all services, no shift rotation. Liberal benefits, advancement opportunities, educational opportunities in area, equal opportunity employer. Apply: Director of Nursing Service, Kaiser Foundation Hospitals, San Francisco 15, California. 15-5-7

Registered Nurses and Certified Nursing Assistants for new, modern hospital owned and operated by the Daughters of Charity, located in the heart of Santa Clara Valley, 1 hr. from San Francisco, close to beaches and mountains. Needed immediately, Nurses for all tours of duty in all services, particularly O.B. and O.R. Excellent geographical location, climate, working environment contribute to your job satisfaction. Apply: Director of Nursing Service, O'Connor Hospital, San Jose, California. 15-5-10

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Staff Duty positions (Nurses) in private 428-bed hospital. Liberal personnel policies and salary. Differential for evening and night duty. Write: Personnel Director, Hospital of The Good Samaritan, 1212 Shatto Street, Los Angeles 17, California. 15-5-3B

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon and night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California. 15-5-3C

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Executive Director generalized public health nursing agency. Potential for program expansion in rapidly growing community 45 minutes from NYC. Staff 8 full time, 5 relief nurses. Master's degree, administrative ability; experience required, salary open. Send résumé to Mr. Charles H. Ulrich, Chairman, Personnel Committee, Visiting Nurse Association, 60 Guernsey Street, Stamford, Connecticut. 15-7-4

General Duty Nurses for 54-bed hospital, minimum starting salary $350 per mo., located near Miami and West Palm Beach. Apply: Director of Nurses, Belle Glade Memorial Hospital, Belle Glade, Florida. 15-10-3

REGISTERED NURSES: for 75-bed, air-conditioned hospital, growing community. Starting salary $330-$365/m, fringe benefits, vacation, sick leave, holidays, life insurance, hospitalization, 1 meal furnished. Write: Administrator, Hendry General Hospital, Clewiston, Florida. 15-10-1

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Staff Nurses and Licensed Practical Nurses (Openings in several areas, all shifts). Minimum starting pay $77 R.N.'s; L.P.N.'s $61 per wk., experience considered, differentials paid for reliefs, nights. Every other weekend off in small community hospital 2 miles from Boston. Living quarters available. Contact: Miss Elizabeth B. Kennedy, R.N., Director of Nursing, Chelsea Memorial Hospital, Chelsea, Mass. 15-22-1

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Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric and pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th Street. Cleveland 6, Ohio. 15-36-1D

Staff Nurses for modern 400-bed tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at $396 with semi-annual increments. Extra for night and relief duty, 5-day work wk., 3-wk. paid vacation, 6 paid holidays, liberal sick leave, comfortable accommodations in nurses' residence at low rate. Learn and earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio. 15-36-1E

Registered Nurse (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $387. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon. 15-38-1

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Director of Nursing,
ROYAL JUBILEE HOSPITAL,
Victoria, B.C., Canada.

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Staff Nurses (All Clinical Services) Base salary $350, opportunities for advancement, differential for 3-11 & 11-7 shifts, personnel policies, sick leave, retirement plan, 3-wk. vacation & laundry of uniforms. Orientation & in-service programs, housing available on campus. Apply: Director of Nursing Service, University of Texas Medical Branch Hospitals, Galveston, Texas. 15-44-5

General Duty Nurses for 235-bed General Hospital; university city; needs 3-11 and 11-7 shift nurses, salary: days $380 - $420; evenings $405 - $445; nights $400 - $440; O.R. start $405 - $445; excellent benefits, including medical and life insurance. Extensive intern-resident educational program. Free quarters available the first month. Must have psychiatric training to obtain a Washington nursing licence. Write Personnel Manager, Virginia Mason Hospital, 1111 Terry Avenue, Seattle 1, Washington. "Work in Seattle and enjoy moderate winters and comfortable summers." 15-48-2B

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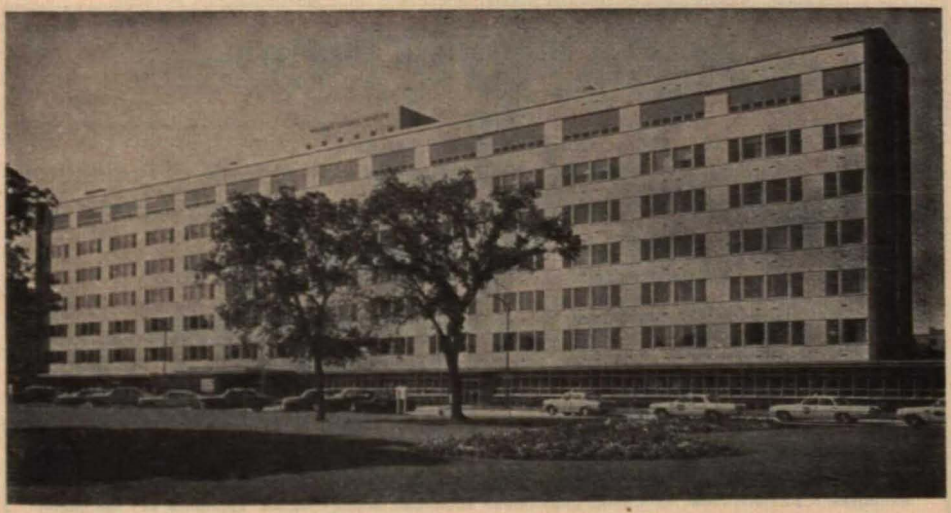


THE WINNIPEG GENERAL HOSPITAL

is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECTLY TO:

THE PERSONNEL DIRECTOR, WINNIPEG GENERAL HOSPITAL
WINNIPEG 3, MANITOBA

SOUTH WATERLOO MEMORIAL HOSPITAL

GALT, ONTARIO

REGISTERED NURSES —— REGISTERED NURSING ASSISTANTS

$320 - $350 per month ———— $196 - $216 per month

257-bed fully accredited hospital. Positions available in all departments. Hospital beautifully located on No. 8 Highway, 60 miles from Toronto by 401. Liberal Personnel policies.

APPLY:

DIRECTOR OF NURSING

REGISTERED NURSES REQUIRED

For General Duty in modern 18-bed private Hospital in Iron mining town, 140 miles north of Sault Ste. Marie, Ontario.

SALARY RANGE $310 MINIMUM TO $360 MAXIMUM

Allowance for experience. Board and room available at $20 per month. Transportation allowance up to $50 after 6 months.

Apply:

SUPERINTENDENT OF NURSES
LADY DUNN HOSPITAL, WAWA, ONTARIO

BERWYN MUNICIPAL HOSPITAL

Requires Registered Nurses for General Duty — Salary $300 to $345 M.S.I.

Apply to:

DIRECTOR OF NURSING
BERWYN MUNICIPAL HOSPITAL - BERWYN, ALBERTA

PUBLIC HEALTH NURSES

REQUIRED FOR HEALTH BRANCH, B.C. CIVIL SERVICE

Positions available for qualified Public Health Nurses in various centres in British Columbia. SALARY: $375 - $462 per month; car provided. An opportunity for interesting and challenging professional service in this beautiful and fast-developing Province. For further information and application forms, apply to The Director, Public Health Nursing, Department of Health Services and Hospital Insurance, Parliament Buildings, Victoria, B.C., or to The Chairman, B.C. Civil Service Commission, 544 Michigan Street, Victoria, B.C.

COMPETITION No. 63:101

POSITIONS OPEN — REGISTERED NURSES

Starting Salary $330 per month - Allowance for experience - Enquiries invited - Personnel Policies on request - 40 Hour Week - 9 statutory Holidays - Room and Board - Nurses' Residence $45 per month
New Hospital to be completed very soon

Apply to: Mrs. G. AUGER

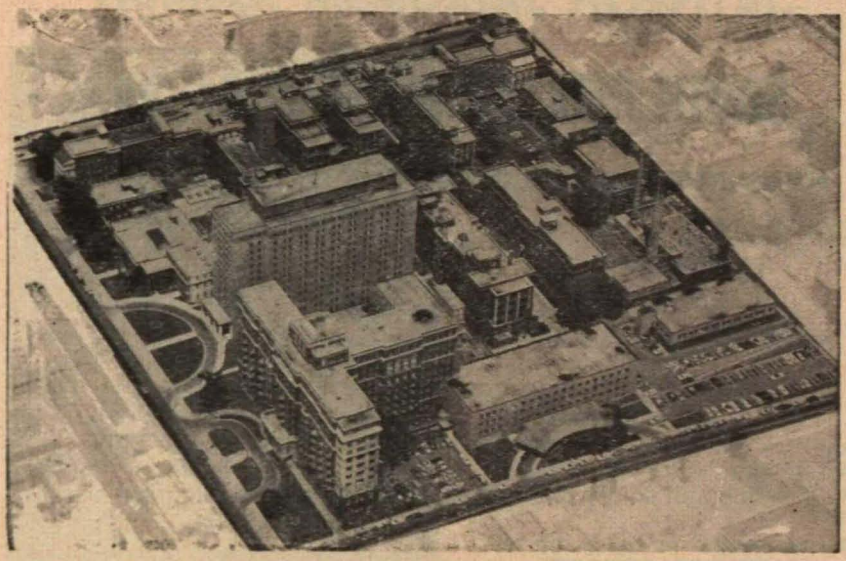
DIRECTOR OF NURSING, LITTLE LONG LAC HOSPITAL, GERALDTON, ONTARIO

REGISTERED NURSE

For private practice in southern California. Starting salary: $385.
Must report for work no less than 60 days.

CONTACT MRS. MARTIN, 10720 S. PARAMOUNT BLVD., DOWNEY, CALIFORNIA.

TORONTO GENERAL HOSPITAL



NURSING OPPORTUNITIES
for
REGISTERED NURSES AND CERTIFIED NURSING ASSISTANTS

Planned Orientation Programme — Inservice Educational Programmes
Opportunity to gain additional knowledge in specialized fields of nursing
Excellent personnel policies
Salaries commensurate with prevailing current salaries in Metropolitan Toronto

For information or application write to:
DIRECTOR OF NURSING, TORONTO GENERAL HOSPITAL
101 College Street, Toronto 2, Ontario

REGISTERED NURSES FOR GENERAL DUTY

in modern 20-bed hospital located in thriving Northwestern Ontario community. Starting salary $275 minimum to $325 maximum for three years' experience. Board and room in modern nurses' residence is supplied at no charge. Excellent employee benefits and recreational facilities available. Further particulars on request.

Apply, giving full details of experience, age, availability, etc., to:

EMPLOYMENT SUPERVISOR,
Marathon Corporation of Canada Limited, Marathon, Ontario.

COURSES FOR R.N.'S N.Y. POLYCLINIC MED. SCH. & HOSP. — in heart of Manhattan — 6-mo. courses in: **O.R. NURSING, OPD. NURSING, MED.-SURG. NURSING.** Classes 4 times yrly: Mar., June, Sept., Dec. Room, meals, Medical Care & monthly cash stipend. Positions available to graduates of our Courses. For information write: Director of Nursing Education, 345 W. 50 St., N.Y.C., NEW YORK. 15-33-24

SOUTH PEEL HOSPITAL, COOKSVILLE

HEAD NURSES AND GENERAL DUTY STAFF NURSES

required for

All departments of a new 450-bed General Hospital situated just 7 miles west of Metropolitan Toronto.

Salaries paid in accordance with the Toronto Schedule.

Many fringe benefits, including portable pensions.

Additional salary allowances for postgraduate qualifications.

For information or application, write to:

DIRECTOR OF NURSING,

South Peel Hospital, Cooksville, Ontario.

QUEENSWAY GENERAL HOSPITAL

has opportunities for male and female

REGISTERED NURSES

to

expand your professional training and skill in our modern P.P.C. accredited hospital where your nursing capabilities may be used to the fullest in a harmonious and congenial environment.

For further information write to:

THE DIRECTOR OF NURSING,
QUEENSWAY GENERAL HOSPITAL,
Sherway Drive, Toronto 18, Ontario.

HUMBER MEMORIAL HOSPITAL

HOSPITAL —
Newly expanded 350-bed hospital. Progressive patient care concept.

SALARY —
1963 schedule General Staff Nurses $325-$375 per month and Certified Nursing Assistants $230-255 per mo.

HOUSING —
Furnished apartments available at subsidized rates.

JOB SATISFACTION —
High quality patient care and friendly working environment, personal recognition and professional development.

You are invited to enquire concerning employment opportunities to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL
200 Church Street, Weston, Ontario - Telephone 249-8111 (Toronto)

GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary $325 monthly with annual increments for 4 years to $365.

Until registration in Ontario is established — $300.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days after one year.

Annual sick time 12 days after one year, unused portion cumulative to 36 days.

Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO

HOSPITAL NURSES required for

Norway House Indian Hospital, Norway House, Manitoba

This hospital is in a beautiful location which serves the Indian population in the area of Central Manitoba.

Accommodation available, good fringe benefits, starting salary to $3,750 plus isolated post allowance of $720 per annum.

Apply to Regional Nursing Supervisor, Medical Services, Central Region, Department of National Health and Welfare, 169 Pioneer Ave., 705 Commercial Bldg., Winnipeg. Manitoba.

YORK COUNTY HOSPITAL

NEWMARKET, ONTARIO

A modern, progressive accredited hospital expanding to 263 beds. Located one hour from downtown Toronto. Has openings for the following personnel:

HEAD NURSES for psychiatric and post partum departments, postgraduate study preferred. GENERAL STAFF NURSES and CERTIFIED NURSING ASSISTANTS.

Top salary scales, excellent personnel policies and fringe benefits which include pension plan.

Apply to:

DIRECTOR OF NURSING

ASSISTANT DIRECTOR OF NURSING

REQUIRED

For a 163-bed General Hospital.

Please reply to:

Director of Nursing,
KIRKLAND AND DISTRICT HOSPITAL,
Kirkland Lake, Ontario.

HAILE SELLASSIE I UNIVERSITY

Addis Ababa — Ethiopia

DEPARTMENT OF NURSING

Applications are invited for two vacancies in the department, as of October 1963.

1. NURSE EDUCATOR — to develop and teach post-basic courses.
2. CLINICAL SUPERVISOR — to teach and to supervise the practice of post-basic studies.

Applicants should have the Masters' degree from a recognized School of Nursing, and both professional and teaching experience. All teaching is done in English.

The salary, free of income tax, will be between U.S. $5,040-$6,720, plus housing allowance and travelling expenses.

Interested candidates please contact:

ACADEMIC VICE-PRESIDENT,
Haile Sallassie I University, P.O. Box 1176, Addis Ababa, Ethiopa

THE GENERAL HOSPITAL OF PORT ARTHUR

Invites applications for the position of

ASSISTANT DIRECTOR OF NURSING SERVICE

SALARY COMMENSURATE WITH QUALIFICATIONS AND EXPERIENCE

Apply to:

DIRECTOR OF NURSING
GENERAL HOSPITAL OF PORT ARTHUR
PORT ARTHUR, ONTARIO

SARNIA GENERAL HOSPITAL

Recently expanded to 350 beds offers excellent opportunities for Nursing Personnel.

1. Head Nurse — Operating Room
   Experienced postgraduate preferred.
2. Registered Nurses — all services including Psychiatric Unit.
3. Registered Male Attendants for Psychiatric Unit.

Excellent personnel policies and benefits. Salary commensurate with experience and qualifications. Sarnia is a progressive industriel city and is a resort area located at the junction of the St. Clair River and Lake Huron.

Apply:

PERSONNEL DIRECTOR,
Sarnia General Hospital, Sarnia, Ontario.

OSHAWA GENERAL HOSPITAL

Oshawa, Ontario

Requires for School of Nursing

CLINICAL INSTRUCTOR IN SURGICAL NURSING

with Certificate in Nursing Education

For further information, apply to:

DIRECTOR OF NURSING,
Oshawa General Hospital, Oshawa, Ontario.

GENERAL DUTY NURSES

SALARY RANGE $327 - $362

Required by Metropolitan Toronto for the new Riverdale Hospital, a 800-bed hospital for chronic and convalescent patients. Shift allowances for afternoon and night shifts. Cumulative sick pay and pension plans are in effect. Permanent positions, 40 hour week.

Apply:

PERSONNEL OFFICE,
387 Bloor Street East, Toronto 5, Ontario.

MONTREAL CHILDREN'S HOSPITAL

invites applications

From Graduate Registered Nurses with Psychiatric postgraduate preparation and Male Child Care Workers to fill vacancies on small 14-bed active Psychiatric Unit. Good personnel policies. Salary commensurate with experience and preparation. Active In-Service Program.

Apply in writing to:

DIRECTOR OF NURSING,
Monreal Children's Hospital, 2300 Tupper Street, Montreal 25, Que.

NURSING INSTRUCTORS

required for

DEPARTMENT OF NURSING EDUCATION, MENTAL HEALTH SERVICES OF B.C., ESSONDALE, B.C. — B.C. CIVIL SERVICE

CLINICAL INSTRUCTORS — to conduct ward teaching program for psychiatric nursing students and affiliates. Salary $376-$450 per month. **CLINICAL CO-ORDINATOR** — to co-ordinate teaching programs for nursing students. Salary $410-$497 per month.

For information and application forms apply IMMEDIATELY to:

THE PERSONNEL OFFICER, B.C. CIVIL SERVICE COMMISSION,
Essondale, B.C. — Competition No. 63:356

SUPERVISORS

Applications are invited to fill newly created positions for Supervisors — day, evening and night. Starting salary $4,800 to $5,700 according to experience.
Accommodation available in nurses' residence.

Apply to:

DIRECTOR OF NURSING, LADY MINTO HOSPITAL,
Chapleau, Ontario.

THE SCARBOROUGH GENERAL HOSPITAL

A new modern hospital located 10 miles from downtown Toronto invites applications from:

REGISTERED NURSES
REGISTERED NURSING ASSISTANTS

Opportunities are offered in Supervisory, Head Nurse and General Duty positions. Services are offered in Medicine, Surgery, Obstetrics, Pediatrics, Emergency and Intensive Care Units.

Salaries commensurate with prevailing current salaries for Nurses in Metropolitan Toronto and adjustable with experience and educational qualifications.

Progressive Personnel Policies, Pension Plan, Orientation and In-service Program.

For further information write to:

DIRECTOR OF NURSING
SCARBOROUGH GENERAL HOSPITAL, SCARBOROUGH, ONTARIO

CORNER BROOK

Graduate Nurses

are invited to enquire re:

Employment opportunities

in Canada's newest Province. Fully accredited 110-bed hospital, progressive community of 27,000. Magnificent scenery and recreational facilities. Transportation advanced. Residence available.

Enquire to:

Director of Nursing
WESTERN MEMORIAL HOSPITAL
Corner Brook, Newfoundland

WOODSTOCK GENERAL HOSPITAL

requires

1. ASSISTANT HEAD NURSE
   for obstetrical department.
   Postgraduate experience essential.
2. GENERAL STAFF NURSES
   1. Obstetrics
   2. Surgical Floor

Apply:

DIRECTOR OF NURSING,
Woodstock General Hospital,
Woodstock, Ontario.

GRADUATE STAFF NURSES

Opportunities for men and women on all services including metabolism, rehabilitation, psychiatry, recovery room, medicine, surgery, pediatrics, obstetrics, operating room, and emergency room. Well planned orientation and in-service programs, tuition-free courses at Western Reserve University after 3 months employment, low cost housing in nurses' residence. Liberal personnel policies with premium for evening and night tours of duty. Starting rate based on experience and education. Staff nurse salary range $385 to $425. Write for more information and the booklet "New Horizons in Nursing," to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITALS OF CLEVELAND

University Circle, Cleveland 6, Ohio

MONTREAL CHILDREN'S HOSPITAL

has vacancies for

1. **Registered Nurses and Certified Nursing Assistants**
   on various wards — Bilingual preferable but not necessarily.
2. **Operating Room Nurses with either postgraduate preparation or experience.**

Apply in writing to:

Director of Nursing
MONTREAL CHILDREN'S HOSPITAL
2300 Tupper Street, Montreal 25, Que.

NURSES

If you desire to practise your profession in a modern and scientific hospital, that has 21 specialties and 1,050 beds, join the nursing staff of

NOTRE DAME HOSPITAL

Generous salaries, according to qualifications, with periodic increases. Differential for evening and night duty, 10 statutory holidays. Vacation based on date of employment. Pension plan. In-service education program. Recreational center

For information, write to:

LA DIRECTRICE DU NURSING
Hôpital Notre-Dame, 1560 est, rue Sherbrooke, Montréal 24

GRADUATE STAFF NURSES

required for

MEDICAL AND SURGICAL AREAS

University teaching hospital. Applicants should be eligible for Ontario Registration. Personnel policies and further information may be obtained from:

DIRECTOR OF NURSING,
Kingston General Hospital, Kingston, Ontario.

GENERAL STAFF NURSE POSITIONS

AVAILABLE

in the General Operating Rooms (includes general surgery, cardiac, neurosurgery, plastic, ear, nose and throat and urology), Gynecological and Ophthalmological operating rooms. Salary commensurate with experience. Opportunities for promotion. Excellent fringe benefits including refund of tuition up to six points per semester.

For further information write:

DIRECTOR, NURSING SERVICE
THE JOHNS HOPKINS HOSPITAL
Baltimore 5, Maryland

ST. JOSEPH'S HOSPITAL

Toronto, Ontario

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

600-bed fully accredited hospital provides experience in Operating Room, Recovery Room, Intensive Care Unit, Pediatrics, Orthopedics, Obstetrics, General Surgery and Medicine.

Orientation and Active In-service program for all staff.

Salary is commensurate with preparation and experience.

Benefits include Pension Plan, Group Life Insurance, Sick Leave — 12 days after one year, Ontario Hospital Insurance — 50% payment by hospital.

Rotating Periods of duty — 40 hour week, 8 statutory holidays — annual vacation 3 weeks after one year.

Apply

ASSISTANT DIRECTOR OF NURSING SERVICE
ST. JOSEPH'S HOSPITAL
30 The Queensway, Toronto 3, Ontario

YOUR INQUIRY

RE:

Opportunities for Registered Nurses at this General Medical Teaching Hospital 30 minutes from Windsor, Ontario.

IS INVITED

Please write or call:

CHIEF, NURSING SERVICE
VETERANS ADMINISTRATION HOSPITAL,
DEARBORN, MICH.

Telephone: LOgan 2-6000, EXT. 336
Excellent working conditions.
Liberal Benefits.
Minimum $5,035.

CLINICAL AND CLASSROOM INSTRUCTOR

with advanced preparation required for August, 1963

APPROVED SCHOOL OF NURSING

Junior students attend Lakehead College for instruction in the basic physical and social sciences and English.

Fully accredited hospital — 300-beds. This is one of the loveliest parts of Canada, and is both a summer and winter sports resort.

For further information write to:

THE DIRECTOR OF NURSING
General Hospital of Port Arthur
Port Arthur, Ontario

GLENROSE PROVINCIAL GENERAL HOSPITAL

requires

SUPERVISOR

and

STAFF NURSES

For Handicapped Children's 30-40 bed Department. Opening date approximately **November 1st, 1963.**

Apply in writing:

THE DIRECTOR OF NURSING SERVICE,
Glenrose Provincial General Hospital, 10230-111th Avenue,
EDMONTON, ALBERTA.

SUPERVISOR

Required for Operating Room Department, 6 theatres, 160-bed hospital. New modern hospital on Vancouver Island. Personnel policies according to RNABC.

For information, write to:

DIRECTOR OF NURSING,
NANAIMO REGIONAL GENERAL HOSPITAL,
Nanaimo, B.C.

ONE REGISTERED NURSE and ONE PRACTICAL NURSE

Wanted immediately for 15-bed company-owned General Hospital in north-western Quebec mining town. Starting salary: $350 and $300 per month respectively. Room and board: $1.00 per day, 42-hour week, 3 weeks annual vacation. Salary increments based on ability and service. Incoming transportation will be reimbursed after 3 months satisfactory service. There are rail, plane and road connections in this area.

Apply in writing, stating references, etc. to:

DR. F. PELLETIER, M.D., OPEMISKA GENERAL HOSPITAL,
P.O. Box 10, CHAPAIS, County Abitibi East, Quebec.

DIRECTOR OF NURSING

FOR

THE LAKESHORE GENERAL HOSPITAL

POINTE-CLAIRE, QUEBEC

DIRECTOR OF NURSING required for a completely new 317-bed hospital to be completed by the end of 1964. Here is an opportunity to plan for and enlist the Nursing Staff for a model, general hospital designed to serve the on-island and off-island residential communities west of Montreal.

University preparation and experience required, knowledge of French desirable.

Please forward complete details of experience, training, etc. before October 14th, 1963 to:

Executive Assistant to the President,
THE LAKESHORE GENERAL HOSPITAL,
444 Beaconsfield Boulevard, BEACONSFIELD, Quebec.

VICTORIA HOSPITAL

LONDON, ONTARIO

Modern 1000-bed hospital

requires

Registered Nurses for all services

and

Registered Nursing Assistants

40 hour week - Pension plan
Good salaries and Personnel Policies.

Apply:

DIRECTOR OF NURSING,
VICTORIA HOSPITAL, LONDON, ONT.

THE REHABILITATION INSTITUTE OF MONTREAL

invites applications for the position of

BILINGUAL CLINICAL INSTRUCTOR

Qualifications — Diploma in Nursing Education essential and teaching experience desirable. Salary commensurate with qualifications and experience.

Apply to:

Director of Nursing,
REHABILITATION INSTITUTE OF MONTREAL,
6300 Darlington Avenue,
Montreal, P.Q.

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

for

360-bed accredited General Hospital. Registered Nurses salary range $315-$355 per month with consideration for contemporary experience or special preparation.

Certified Nursing Assistants $210 - $240 per month.

For further information write:

Director of Nursing Service
METROPOLITAN GENERAL HOSPITAL
Windsor, Ontario.

THE VANCOUVER GENERAL HOSPITAL

Continuing and temporary appointments

for

GENERAL DUTY NURSES

are currently available. Full range of employee perquisites with monthly salary of $325 ($341 for two years of experience) rising to $374 per month.

Please address correspondence to:

PERSONNEL DIRECTOR
THE VANCOUVER GENERAL HOSPITAL
10th AND HEATHER,
Vancouver, B.C.

NATIONAL VOLUNTARY HEALTH ASSOCIATION

requires an

ASSISTANT TO THE NATIONAL DIRECTOR OF THE CHRISTMAS SEAL CAMPAIGN

University graduate, preferably with experience of community health organization and business training. A knowledge of French necessary. To work on all aspects of the Christmas Seal Campaign in Canada in co-operation with provincial associations. Opportunity for early promotion. Salary and benefits — $4,800 per annum to commence; pension plan.

Applications and enquiries to:

DR. C. W. L. JEANES, EXECUTIVE SECRETARY,
CANADIAN TUBERCULOSIS ASSOCIATION,
343 O'Connor Street, Ottawa 4, Ontario.

OPERATING ROOM SUPERVISOR

REQUIRED

200-bed General Hospital fully accredited
Pleasant City — 3 colleges
Good salary and personnel policies

For further information apply to:

The Director of Nursing,
GUELPH GENERAL HOSPITAL,
Guelph, Ontario.

ST. JOSEPH'S HOSPITAL

HAMILTON, ONTARIO

A modern, progressive, 850-bed hospital located in the centre of Ontario's Golden Horseshoe, has openings for:

1) Head Nurses for Medical or Surgical units. Postgraduate study preferred.
2) General staff nurses in all clinical areas.
3) Certified Nursing Assistants in all clinical areas.

For further information write to:

THE DIRECTOR OF NURSING SERVICE
St. Joseph's Hospital, Hamilton, Ontario.

UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

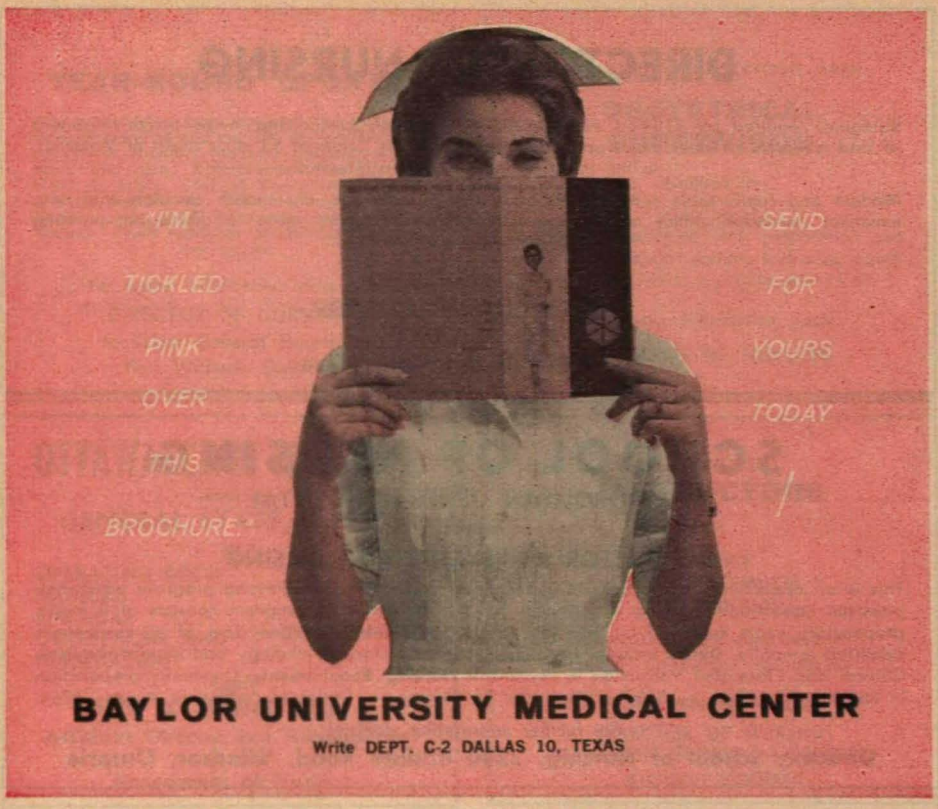
Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week.

Salary range $300 to $360 gross per month. Differential for evening and night duty. Temporary residence accommodation if desired.

Apply to:

DIRECTOR OF PERSONNEL, UNIVERSITY HOSPITAL,
Saskatoon, Saskatchewan.



BAYLOR UNIVERSITY MEDICAL CENTER

Write DEPT. C-2 DALLAS 10, TEXAS

MEMORIAL HOSPITAL, BOWMANVILLE

ONTARIO

Offers excellent opportunities for

REGISTERED NURSES

and

REGISTERED NURSING ASSISTANTS

In modern well-equipped 166-bed General Hospital, new wing with 116 beds opened in 1962.

Good salaries and modern separate residence accommodation, excellent personnel policies and working conditions.

For full information, apply to:

DIRECTOR OF NURSING

CLINICAL INSTRUCTOR

in

MEDICAL and SURGICAL NURSING

Required for 350-bed General Hospital. Modern classrooms and facilities. Present student enrollment — 95.

Minimum qualification — Diploma in Nursing Education; Degree preferred. This is an excellent opportunity for the successful candidate to use progressive techniques in teaching.

Apply:

Personnel Director,
SARNIA GENERAL HOSPITAL,
Sarnia, Ontario.

DIRECTOR OF NURSING

Bilingual, required for 110-bed, fully accredited Hospital, specializing in the active treatment of and research in Tuberculosis and other Chest Diseases. Situated 55 miles north of Montreal, in the heart of the Laurentian Mountains.

Modern and comfortable suite accommodation, 40-hour week, one month vacation with pay, excellent personnel policy with conventional benefits. Salary open to discussion, pending experience and qualifications.

Please apply to:

THE EXECUTIVE DIRECTOR,
P.O. Box 1000,
Ste. AGATHE des Monts, Que.

SCHOOL OF NURSING

METROPOLITAN GENERAL HOSPITAL

requires

INSTRUCTOR IN PSYCHIATRIC NURSING

This is an opportunity to participate in the development of a progressive program which emphasizes educational nursing experiences for the student. The program consists of 2 basic, preparatory years followed by one year of Nursing Internship. One class of 32 students is admitted annually. **Duties include:** Instruction in Introductory Psychology and Mental Hygiene. Clinical and Classroom Instruction in Psychiatric Nursing. **Requirements:** University preparation in Nursing Education. — Salary differential for Degree. — Duties to commence August, 1964.

For further information, contact:

Director, School of Nursing, 2240 Kildare Road, Windsor, Ontario

OAKVILLE-TRAFALGAR MEMORIAL HOSPITAL

OAKVILLE, ONTARIO.

General Duty Nurses required for all departments (including operating room) in modern 163-bed fully accredited hospital, expanding to 340 beds. Oakville is a progressive community situated on Lake Ontario just twenty miles from the cities of Toronto and Hamilton. Excellent salaries and personnel policies. Modern apartment-style staff residence under construction. Further details will be furnished on request.

Apply:

Director of Nursing,
OAKVILLE-TRAFALGAR MEMORIAL HOSPITAL,
Oakville, Ontario.

CENTRAL NEWFOUNDLAND HOSPITAL

requires

1. An INSTRUCTOR to start a course for certified Nursing Assistants in a new modern 200-bed hospital located 60 miles from Gander International Airport. Student enrollment: 25.
2. HEAD NURSE for 15-bed Intensive Care Unit.
3. HEAD NURSE for Self-Care Unit.

Personnel policies and further information may be obtained from:

DIRECTOR OF NURSING
CENTRAL NEWFOUNDLAND HOSPITAL, GRAND FALLS, NEWFOUNDLAND

SUPERINTENDENT OF NURSES

Required by 18-bed Private Hospital. Ontario registration required.
Registered Nurse with supervisory experience or experience as Superintendent of small hospital would fill requirements. Two room apartment with bath and all meals supplied for $20 per month. Four weeks annual vacation per year, eight statutory holidays, hospitalization, medical-surgical and Group Insurance. Moving expenses up to $50 refunded following six months employment. Salary scale will be forwarded following application.

Apply to:

MRS. V. M. SWITZER, SECRETARY,
BOARD OF DIRECTORS, Lady Dunn Hospital, Wawa, Ontario.

YEAR-ROUND SPORTS

Are available at the Lakehead. The McKellar General Hospital and the City of Fort William, provide a friendly, pleasant atmosphere for work and play. Registered Nurses are invited to apply. Cost of transportation here will be prepaid for those staying one year. Basic salary: $325 for nurses registered in Ontario. Good residence accommodation, $30 per month.

For further information, write to:

DIRECTOR OF NURSING,
McKellar General Hospital,
Fort William, Ontario.

CITY HOSPITAL, SASKATOON, SASK.,

OBSTETRICAL SUPERVISOR

Required for

(340 beds)

Salary commensurate with preparation and experience. Liberal vacation with pay, cumulative sick leave, superannuation plan.

For further information, apply:

DIRECTOR OF NURSING

OTTAWA CIVIC HOSPITAL

requires

GENERAL STAFF NURSES

for

OPERATING ROOM
MEDICAL
SURGICAL
OBSTETRICAL AND
PSYCHIATRIC
} DEPARTMENTS

Apply

EDITH G. YOUNG, REG. N.,
Assistant Director and Administrator of the Department of Nursing

---

INSTRUCTORS

for

SCIENCE
SURGICAL-CLINICAL
O.R. CLINICAL

University preparation required
Salary differential for degree

For further information apply to:

DIRECTOR OF NURSING
BRANDON GENERAL HOSPITAL
Brandon, Manitoba

QUEEN ELIZABETH HOSPITAL

OF MONTREAL

Positions available for Registered Nurses, general duty in a recently enlarged and modernized 273-bed General Hospital in residential area. Progressive Patient Care currently in effect with intensive intermediate and self-care units established. Positions available also in Obstetrical Department. Salaries and policies are in accordance with the recommendations of the Association of Nurses of the Province of Quebec. Differential paid for permanent evening and night duty. For further information

please make appointment or write to:

DIRECTOR OF NURSING,
Queen Elizabeth Hospital of Montreal,
2100 Marlowe Ave., Montreal 28, Que.

PARRY SOUND GENERAL HOSPITAL

PARRY SOUND, ONTARIO

Applications for the position of Instructor in the Nursing Assistant Centre.

Please submit application including teaching experience and qualifications, to:

DIRECTOR OF NURSES,
The Parry Sound General Hospital,
Box 1450, Parry Sound, Ontario.

REGISTERED NURSES

required for:

82-bed hospital. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates and personnel policies apply to:

DIRECTOR OF NURSING
Haldimand War Memorial Hospital
Dunnville, Ontario

REGISTERED NURSES

required for

ORILLIA SOLDIERS' MEMORIAL HOSPITAL

ORILLIA, ONTARIO

Minimum Salary: $3,600 with regular increments. All normal fringe benefits. New Wing being added.

For further information, apply in writing to:

MISS B. M. JONES,
Director of Nursing,
Orillia Soldiers' Memorial Hospital,
Orillia, Ontario.

THE McKELLAR GENERAL HOSPITAL

SCHOOL OF NURSING

requires

Two (2) qualified Instructors in Basic Nursing Arts and in Medical-Surgical Nursing.

Those interested in joining a progressive, dynamic school, are invited to write for more information to the:

DIRECTOR OF NURSING,
McKellar General Hospital,
Fort William, Ontario.

REGISTERED NURSE

for

110-bed "HOME FOR THE AGED" with 50-bed bed-care wing. Located on Grand River, Niagara Peninsula within 1 hour's travel to Hamilton, Niagara Falls and Buffalo, N.Y. Modern staff quarters optional.

For full particulars apply:

SUPERINTENDENT

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